DOCUMENT RESUME

ED 304 486 UD 026 514

AUTHOR	Sosin, Michael R.; And Others
TITLE	Homelessness in Chicago: Poverty and Pathology, Social Institutions and Social Change.
INSTITUTION	Chicago Univ., Ill. School of Social Service Administration.
SPONS AGENCY	Chicago Community Trust, Ill.; Illinois State Dept. of Public Aid, Springfield.
REPORT NO	ISBN-0-9615118-0-X
PUB DATE	Jun 88
NOTE	416p.
PUB TYPE	Reports - Research/Technical (143)
EDRS PRICE	MF01/PC17 Plus Postage.
DESCRIPTORS	*Economically Disadvantaged; Economic Factors; Employment Opportunities; *Homeless People; *Human Services; *Individual Characteristics; Low Income Groups; *Poverty; Poverty Programs; Public Policy; Social Influences; Urban Problems; *Welfare Services
IDENTIFIERS	*Illinois (Chicago)

ABSTRACT

All of the very poor have a certain potential for homelessness due to traditional economic reasons. This report on the homeless in Chicago (Illinois) presents an overview of a two-part project whose goals are to determine the following: (1) how to prevent homelessness; (2) how to relieve homelessness; and (3) how to reverse homelessness. The characteristics of homelessness are examined in a survey of 535 individuals who represent a random sample of those who obtain their main meal of the day from a free meal program, a shelter, or a residential treatment program for the indigent. Also examined are the social institutions and the general social and economic conditions in Chicago that are associated with homelessness and poverty. Major findings include the following: (1) homelessness is not always constant and long-term; (2) typical characteristics of the homeless include military service, out-of-home care as a child, and mental illness or alcoholism; (3) the distinguishing characteristic of the homeless is that they tend to live alone when they do have a residence; and (4) the homeless use social services more frequently than the poor who have homes. Policy recommendations focus on work as the central issue in preventing, relieving, and reversing homelessness. Statistical data are included on 73 tables. A list of 90 references is also included. (FMW)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED304486

HOMELESSNESS IN CHICAGO:

Poverty and Pathology, Social Institutions and Social Change

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☒ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
● Points of view or opinions stated in this document do not necessarily represent official OERI position or policy

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Michael R. Sosin
Univ of Chicago
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Michael R. Sosin
Paul Colson
Susan Grossman

School of Social Service Administration
The University of Chicago

The Chicago Community Trust

June 1988

UD026514

Support for this study was provided by The Chicago Community Trust. Support was also provided by the Illinois Department of Public Aid. The conclusions and opinions expressed in this report are those of the authors and do not necessarily reflect the views of the institution with which they are affiliated, nor those of The Chicago Community Trust or the Illinois Department of Public Aid which provided financial support for the research on which the report is based.

HOMELESSNESS IN CHICAGO:

POVERTY AND PATHOLOGY

SOCIAL INSTITUTIONS AND SOCIAL CHANGE

Michael R. Sosin

Scholar-in-Residence
School of Social Service Administration
The University of Chicago

Professor
School of Social Work
Institute for Research on Poverty
The University of Wisconsin at Madison

Paul Colson
Susan Grossman
Research Assistants
School of Social Service Administration
The University of Chicago

prepared for
Scholar-in-Residence
The Chicago Community Trust
June 1988

Copyright 1988, The School of Social Service Administration, The University of Chicago

ISBN: 0-9615118-0-X

Executive Summary

The plight of Chicago's homeless is increasingly apparent. At any time, numerous individuals and families can be seen searching trash cans for food, sleeping outside, or residing in shelters. A good deal of evidence suggests that the number of homeless individuals has increased over the last decade; no decline seems to be imminent.

There have been some attempts to describe the homeless population in Chicago and several attempts to ameliorate their difficulties. However, we actually know far too little about the service needs of this population and have often developed policies without basic facts.

It is important to consider both why individuals are very poor, and also what causes some of these individuals to become homeless. And, the nature of poverty and homelessness can only be fully understood when the nature of the social institutions surrounding this population--from shelters and food pantries to the welfare system and the broader local economy--are considered. Also to be considered are the broader social and economic problems specific to Chicago.

Accordingly, this document presents an overview of a two-part project. One part is a survey of 535 individuals who represent a random sample of those who obtain their main meal of the day from a soup kitchen or other free meal program, a shelter, or a residential treatment program for the indigent. The survey is designed to explore the traits of the very poor and to determine whether the homeless have unique traits compared to other members of this group. In addition, this research project examines the social institutions of Chicago that surround homelessness and poverty as well as the general social and economic conditions.

Homelessness over a lifetime. A common, and almost unconscious, assumption in the literature is that homelessness is a nearly constant and long-term status. That is, it often is assumed that individuals fall into homelessness once and then remain in this state for a very long period. Our findings indicate that a moderate share of those who are homeless have been in this state for a long, continuous period. But this is not common. At any point in time, roughly half of the homeless are experiencing homelessness for the first time. These individuals are typically homeless for 6 months or less.

The other half of those who were homeless at the time of the interview have been homeless more than once. The typical individual in this group claims to have been homeless on and off for about eight years. The most common report was of four periods of homelessness before the current one. On average, homelessness was experienced for three years out of the eight.

It also appears that homelessness strikes many of those who are very poor--more so than other works on the topic may suggest. Among those respondents who were not homeless at the time of the interview, roughly half had been homeless in the past. Typically, such individuals also began a cycle of homelessness about 8 to 10 years ago and have been homeless for about 2 years since then.

What is typical and what is unique. Some traits that are typically thought to cause homelessness seem to be common among all of the very poor. For example, there are few, if any, differences in general background when comparing those who have had some experience with homelessness and those who have not. About half of both groups had been married at one time. Both groups are heavily minority and typically male. About one-fourth of both groups are women with children. For both those with homeless experience and those without homeless experience, nearly everyone had worked. Most individuals had worked roughly half the time since becoming an adult and at one time had a salary that was equivalent to what a minority, working-class male or female might expect. Fewer than one-third of the sample was presently working; the typical individual lost his or her best job as long as 10 years ago. Given that few in the sample had achieved more than a high school diploma, it is likely that these individuals had a reasonable working-class-level job when in their early or mid-twenties, lost it, and with the general decline in blue-collar jobs, were unable to find new work.

The differences between those with and those without homelessness experience are more subtle. In terms of their lifelong histories, those who have been homeless are indeed more likely to have been in a mental hospital. While a very large proportion of the entire sample has symptoms of mental illness, such symptoms are somewhat more common among the homeless. Similarly, those with homeless experience are slightly more likely to demonstrate symptoms of alcoholism. However, such sets of issues are contributors to homelessness only to a limited degree. Generally, differences of ten to fifteen percentage points emerge when the homeless and domiciled are compared. And, with few exceptions, strict multivariate statistical comparisons suggest at best small causal roles for such factors.

Unexpected differences are found in respondents' involvement with other institutions. While differences are only moderate, those with homeless experience are more likely to have served in the military and to have been in some sort of out-of-home care (e.g., foster care) as a child. Most striking is that the vast majority of those who have been homeless in the past or are so at present, live alone when they have a residence. They also are likely to live only with children. Finally, the homeless typically pay higher rents, comparing the cost of their last residence to the current rent paid by domiciled respondents.

Multivariate analysis reveals that current living arrangements are very important. Indeed, the relations to homelessness of such factors as military experience, out-of-home care, and mental hospital experience disappear when current living arrangements are held constant. Further analysis suggests that living arrangements are important because those who do not live with other adults are less able to overcome financial difficulties. Living alone is not particularly associated with mental illness, alcoholism, or alienation from society.

A moderate proportion of those who are homeless lived with relatives before the current homeless period. Between 14 and 20 percent of the sample lived with relatives other than a spouse or children. This finding contradicts the view that most homeless individuals have been rejected recently by their immediate families and could avoid homelessness if the rejection could be reversed. While staying with relatives may help some individuals avoid homelessness, many may not have the option of "doubling up."

The homeless use general social services more frequently than those who have no homeless experience. This finding contradicts the view that homeless individuals do not attempt to use social institutions. However, those who were homeless at the time of the interview often have been "shortchanged" by service systems. A large proportion of those homeless individuals who were once in a mental hospital has stopped using mental health outpatient services, after a period of utilization. Further, some who had been homeless in the past were not referred to stable residences when leaving a mental hospital. In terms of welfare, many of the homeless (37% of those who had ever applied for welfare) had experienced either a refused application or a cutoff from a welfare program during the last six months. In general, a lack of current welfare benefits is an important reason for homelessness; only 45 percent of the homeless receive benefits, including some who recently obtained aid after a previous negative experience. The homeless also earn somewhat less from work.

We conclude that all of the very poor have a certain potential for homelessness. They are in jeopardy largely due to traditional economic reasons, such as a lack of opportunity, relatively low levels of education, and minority status. The low level of welfare benefits and rising costs of housing also appear to be involved. Homelessness becomes more likely under a number of conditions, such as when welfare is cut off or when an individual is denied benefits. Those whose income is marginally lower due to fewer work hours, or whose cost of housing is unusually high, also are more likely to be homeless. For a few, such individual problems as mental illness or alcoholism may also be important. For a large group, not living with others who can share expenses might increase vulnerability.

Policy implications. The lack of jobs, low level of welfare benefits, and housing problems of all members of the sample suggest a link between basic structural conditions of the city, state, and nation, and homelessness. Nevertheless, there might be ways of reducing the extent to which homelessness and extreme poverty occur with more modest resources.

Because major differences among the sample are more tangible than psychological, our policy suggestions focus on material issues. For example, we suggest that, because most members of the sample have some work history and no severe disabilities, work is a central issue. A supported work program can ameliorate most financial needs of this population, add to the personal dignity of the very poor, and perhaps lead some of these individuals into the labor force again.

Help with specific tangible problems is also important. Many of the homeless are eligible for income maintenance benefits and might obtain them with assistance. Aid in avoiding eviction or relocation is also important. Further, we suggest that more aid be offered through meal programs, drop-in centers, and programs that serve the alcoholic and mentally ill. A special public assistance outreach program may also be of benefit.

Existing social institutions need improvement. Work-related mandates in General Assistance programs appear to contribute to a loss in welfare benefits. These mandates might be eased, as could a number of more specific regulations in AFDC. Findings on patterns of service use and problems suggest that emergency public assistance programs, shelter capacity and services, and meal programs need to be expanded. Finally, many mentally ill individuals who are in danger of becoming homeless apparently require more advocacy and tangible services than most relevant agencies can now provide.

The plight of the homeless can be alleviated. The myths and stereotypes must be dispelled, and the causes and needs must be more accurately identified. Only then can we adopt policies and implement programs that effectively address the problem of homelessness and promote the safety and security of the very poor.

Table of Contents

Chapter 1 Page

Introduction 1

BACKGROUND. 2

THE CURRENT STUDY 8

OVERVIEW OF THE SAMPLE. 22

IMPLICATIONS FOR RESEARCH 34

ORGANIZATION OF THE REPORT. 36

Chapter 2

General Economic Conditions, Social Structure, and Demographics 38

TRENDS: POPULATION LEVEL. 39

ALTERNATIVE EXPLANATIONS. 47

SURVEY RESULTS. 50

THOSE WHO HAVE EVER BEEN HOMELESS 51

THE CURRENTLY HOMELESS. 71

STATED REASONS FOR HOMELESSNESS 82

SUMMARY 92

Chapter 3

The Mental Health System 95

INTRODUCTION. 95

ILLINOIS' MENTAL HEALTH SYSTEM. 99

SUMMARY AND CONCLUSIONS 126

DATA ANALYSIS 128

SUMMARY AND CONCLUSIONS 170

Chapter 4

Income Maintenance 174
- CASE STUDY DATA 176
- STATISTICAL RESULTS 197
- CONCLUSION. 232

Chapter 5

Services and Supports in Chicago 235
- THE ROLE OF SERVICES. 235
- STATISTICAL RESULTS 260
- CONCLUSION. 310

Chapter 6

Some Further Analyses. 312
- LOGISTIC REGRESSIONS. 313
- SEARCHING FOR HOMELESS TYPES. 332
- CONCLUSION. 339

Chapter 7

Summary and Conclusion 340
- HOMELESSNESS RECONSIDERED 342
- IMPLICATIONS FOR POLICY 355
- CONCLUSION. 377

References 380

Appendix A: Tables A1 - A9 387

Appendix B: Table B1. 397

Preface

In January of 1986, the School of Social Service Administration at the University of Chicago and the Chicago Community Trust combined to create the Scholar-in-Residence program. This program was an experiment in the relation between university research and city public policy. The program was to bring to Chicago an expert in a policy area for a one to two year term. The expert would assess some of the relevant policy issues in Chicago and would also attempt to add a perspective to defining and even solving a social problem. The first Scholar-in-Residence project was homelessness in Chicago. For this project, financial support was also received from the Illinois Department of Public Aid.

We carried out the homelessness project under the assumption that basic knowledge about the phenomenon was lacking. It was important to learn more about an array of issues that ranged from the nature of the homeless to the nature of the social institutions that might serve the homeless. The knowledge might alter views about homelessness and might also help direct policy. Accordingly, this is both a basic research project and an applied project.

This document is one outcome of the project: a long report about homelessness and what might be done about it. It is only one product, however. Meetings have been held with many officials to present the preliminary findings and also to make suggestions based upon them. Ideas have been exchanged throughout the period of interviewing officials. And the project team will remain available for further questions.

The project was conducted with continuing input from a number of groups and individuals. These included officials from the Chicago Community Trust and Illinois Department of Public Aid. Also consulted were officials at many levels of government and from the private sector. Indeed, one part of the project involved engaging in formal interviews those who had some knowledge of the homeless, the social service system, or the general structure of the economy and local community. These interviews were used not only to gather information about homelessness, but also to obtain suggestions about the issues that should be examined. For example, interviewees included representatives from the Chicago Coalition for the Homeless, the Mayor's Task Force on the Homeless, the Community Emergency Shelter Organization, the Chicago Department of Planning, the Jewish Federation, and the Illinois Department of Mental Health and Developmental Disabilities. Researchers with similar interests were consulted, as well.

This procedure was supplemented by the establishment of a formal advisory group through the auspices of the Research Committee of the Mayor's Task Force on the Homeless. This group met to specifically consider a questionnaire, to be directed to homeless and other poor individuals in Chicago. Preliminary and summary talks were also conducted at various points at the University of Chicago.

A very important factor in this project was the existence of a second project on homelessness. Along with Professor Irving Piliavin, the senior author of this document conducted a study of the homeless of Minneapolis through the auspices of the Institute for Research on Poverty at the University of Wisconsin-Madison. Much of the questionnaire was an adaptation of the instrument used in Minneapolis. In addition, the fieldwork concerning the structure of the service system in that city helped to speed the conceptualization of the Chicago service system. More generally, the Chicago project could not have been completed without the conceptual help, data handling procedures, and interviewing techniques borrowed from the Minneapolis project. This report is, in some way, one product of a much broader examination of homelessness.

We would like to thank many of those who helped conduct this project. This, of course, most importantly includes those who were interviewed: a sample of homeless and other poor individuals in Chicago, as well as the many interviewed officials. With a few exceptions, cooperation has been outstanding.

We would also like to thank the project liaisons, Stuart Wegener of the Chicago Community Trust and Larry Wall of the Illinois Department of Public Aid. Also important was the support of colleagues at the University of Chicago, particularly Dean Laurence E. Lynn, Jr. of the School of Social Service Administration, who was instrumental in establishing the program and the project. Advice and services at the University of Wisconsin were obtained from Irving Piliavin, Thomas Corbett, Herb Westerfelt, Karen Heimer, Joyce Collins, Diane Knott, Cathy Esser, and Laura Friedrichs. General information on homelessness from Al Kohls and Mary Erpelding of the Hennepin County Community Service Department was also invaluable. Those who were particularly helpful at the University of Chicago included Keith Madderom, Mary Zaglifa, Edwina Simmons, Julie Dalla Rosa, Jeffrey Gore, Francine Atwell, Rich Lipinski, and Debora Schnitzer. We regret that we may have neglected to mention many others whose help went far beyond what we expected.

We hope that this report and the project that it represents return the faith in us demonstrated by the above, and many other, individuals.

Michael R. Sosin
Paul Colson
Susan Grossman

Chapter 1

Introduction

The early 1980s witnessed a sudden and sustained academic and policy interest in survival needs, which are the most severe social welfare problems. This followed from the apparent growth in the number of individuals who were in jeopardy. For example, the number of individuals who used food programs doubled or tripled in a five-year period (Sosin, 1986). Over the same period, shelters for the homeless generally also reported pronounced increases in the numbers of requests for housing and of applications denied for lack of space (Freeman and Hall, 1986).

For homelessness, in particular, there has been no return to the lower levels of the mid-1970s, even after the economy improved during the mid-1980s. Therefore, the problem continues to attract attention from policymakers and researchers. In Chicago, policies have largely focused on furnishing more beds for shelter and on increasing the supply of food. Some attention has also been paid to changing procedural and access rules in social welfare and service programs to ease entry of the homeless.

The upsurge in homelessness also has led some researchers to seek explanations of homelessness, or at least to search for some notion of the nature of this most disadvantaged population. Studies nationwide and in Chicago focus on the relatively young age of the homeless, the preponderance of members of minority groups, the large numbers of single individuals and the growing proportion of women with children. Mental health problems, dire economic predicaments, and painful day-to-day lives of the homeless have also been documented. At the same time, studies of how the larger social order might effect the rate of homelessness focus on increasing rates of unemployment, deindustrialization, deinstitutionalization of the mentally ill and lack of services, welfare cut-backs, and housing shortages (Farr et al., 1986; Lane and Depp, 1986; Rossi et al., 1986; Morse et al., 1985; Roth et al., 1985; Hopper and Hamburg, 1984; U.S. Department of Housing and Urban Development, 1984; Arce et al., 1983; Stevens et al., 1983; Hombs and Snyder, 1982; Baxter and Hopper, 1981; Rousseau, 1981).

However, most policies and studies are still at a preliminary level. The great majority of policies focus on ameliorating the most direct consequences of homelessness and rarely focus on reversing or preventing the phenomenon. Some studies focus on policy, but do not have a very sound notion of the homeless population on which to base policy suggestions. Other studies have looked at the characteristics of the population, but have used poor theoretical models or have applied flawed research designs.

The current study attempts to improve on this situation. It focuses on Chicago, and attempts to bring a somewhat more comprehensive view of "causes" of homelessness to light. Hopefully, this will enables us to make comprehensive policy suggestions for this city that might also help to advance solutions. This research thus attempts to combine some elements that are all too frequently kept separate: policy with a knowledge of the population, theory with survey methods, and an examination of the community with an examination of individuals.

BACKGROUND

There have been numerous periods of apparent increases in homelessness. There also have been some studies of homelessness before the recent series, summarized above, particularly in the 1930s and 1960s, (Anderson, 1923;

Sutherland and Locke, 1936; Bogue, 1963; Bahr and Caplow, 1974). However, homelessness is still not well understood. Indeed, problems with recent investigations are so broad as to practically defy classification. For example, some problems involve limits in sampling design that make any generalizations about the homeless questionable. One review notes that 53 percent of all recent studies were conducted at one site in one city; 44 percent include only those individuals residing in shelters and not those who live "on the streets." Indeed, less than half of all reviewed studies used any form of random sampling (Milburn _et_ _al_., 1984).

Another methodological issue is that many studies are limited in both questions asked and data analysis. Studies might focus mostly on mental illness or drug abuse; on work history; or on life on the streets. Very few attempt to adopt a broad view in which a large number of the possible causes for homelessness are considered simultaneously. We do not know, for example, the degree to which the "economically" homeless are also those with mental health problems. In other words, it is likely that such problems as a lack of a job, mental health problems, alcoholism, and so on are all involved in homelessness. But little is known about which is most important, and how such factors interact.

Homelessness and Extreme Poverty

There are also conceptual problems. One issue of particular importance is the failure to distinguish homelessness from extreme poverty. That is, most studies of the homeless compare results with those obtained from the whole population of a geographic area. Any differences that are found, from mental illness to a lack of an education, are identified as possible "causes" of homelessness.

This is not a refined approach. On nearly any characteristic, the very poor will generally appear disadvantaged; they will have less education, poorer mental health, perhaps higher levels of alcoholism, lower levels of marriage, and so on. Reporting these facts tells us little. A study should instead attempt to disentangle the traits of the poor in general from those of the homeless. One might find that the two groups are similar, in which case one would assume that homelessness and poverty go hand in hand. It might be that the two groups vary on some characteristics, in which case it is somewhat more correct to call the differences possible causes of homelessness. More complex possibilities also need to be considered in detail. For example, the homeless may score very high on a characteristic found at lower levels among the poor, but not at all among the general population.

The distinction between extreme poverty and homelessness is important. If the homeless are just like the rest of the very poor, then dealing with poverty is the best way to ameliorate homelessness. If the two groups differ greatly, then separate approaches need to be taken. If there are similarities in general, with a few differences, this might suggest targeting only certain policies.

Levels of Analysis

Studies also have all too often segregated their analysis of the population from their analysis of the broader environment. Studies might focus on the general trends in the economy and impute increases in homelessness to any change in the economy that happened to occur at the time of the growth of homelessness. This approach is simplistic. It might be, for example, that the homeless are a group of the long term poor who are unaffected by particular changes in any given component of the economy because they have never participated in it. At the same time, studies that look at individual phenomena, like mental illness, impute causality to problems in the mental health system. For this to be the case, one needs to trace the causes to problems in the mental health system, and not simply impute them. The study thus should look at both community and individuals, and attempt to integrate all components.

Policy Issues

Historically, every era has linked the study of homelessness to policy questions, and every era also has witnessed a remarkable consistency in the major policy issues of the day and the way in which homelessness was defined and addressed (Stern, 1984). It is no coincidence, for example, that in the time of the Poor Law of 1601, the homeless apparently were viewed as able-bodied but unwilling to work; the English nobility decided that workers were needed, particularly for non-traditional industrial employment. In the United State in the 1950s (to use one example), when poverty was considered to be nearly synonymous with pathology, homelessness was often considered in terms of a failure to marry, social alienation, or alcoholism.

It therefore is no surprise that the focus in the 1980s is on what many believe to be the core social issues of the decade. With a general assumption that income distribution is becoming less egalitarian, that minority groups are being left further behind, and that services are being cut back, homelessness research tends to use these issues as the context of investigation.

Nevertheless, there are many more contradictory policy views about the homeless than is generally assumed. Moreover, while each view may have some currency, it is often overstretched and oversimplified without adequate empirical support. Details of some of these arguments will be presented in later chapters, but one example should make it clear that the necessary explanations must be more detailed if they are to be policy relevant.

Perhaps the most common viewpoint is that homelessness is a result of mental illness. Many have linked the alleged increase in the phenomenon to the deinstitutionalization of the mentally ill. A common argument is that individuals have been "dumped" from the mental hospitals to the street, and that those who are unable to make it on their own become homeless.

Yet, there are major flaws in the analyses. It indeed is true that there have been well-documented examples of "dumping." But clearly this is a far too simple explanation for the majority of homelessness. On the one hand, the emptying of mental hospitals occurred roughly a decade before the increase in homelessness is reported to have occurred; if there is a direct relation between deinstitutionalization and increases in homelessness, the historical timing does not support it. On the other hand, most studies of the homeless discover that, even among those with mental problems, only some were ever in an institution. Limiting "dumping" would not solve the entire problem; services to deal with those whose mental health problems occur later, after homelessness has taken place, might also be needed.

With such limits in mind, a few commentators have begun to develop more sophisticated arguments. For example, it may be that individuals who, in the past, would have been committed to an institution, no longer receive any mental health services at all. Or, it is possible that there have been reductions in alternate living arrangements for the mentally ill, such as intermediate care facilities, which gradually result in increased homelessness as the mentally ill run out of options. Or, perhaps the number of mentally ill homeless individuals has not increased at all, but fewer return as frequently to institutions as they did in the past, leaving more individuals on the streets. These examples suggest the need for various alternative services that might help prevent homelessness.

Assuming that these explanations are true in part, they too are overstatements. The vast majority of mentally ill individuals are obviously not homeless; it is difficult to indict the entire system on the basis of those who do not have a home. Any policy suggestions must account for the very specific differences: are those who are mentally ill and those who are homeless different in mental illness, age of onset, willingness to use services, access to services, access to relatives and friends? Would not the answers to such questions call for very specific policies toward specific groups?

Each such difference may have implications for when to intervene. If the problem is one of poor placements for those who are just leaving a mental hospital, for example, services might be directed toward preventing homelessness through better placements. If the issue is the lack of supports for those who have already become homeless and then become mentally ill, programs might aim at reversing homelessness.

THE CURRENT STUDY

We recognize that no one study can ascertain all that needs to be learned about homelessness; the phenomenon is too complicated, and like most others, will take years of concentrated effort to understand with any depth. Nevertheless, we have attempted to build a more comprehensive study by including a wide range of policy conceptualizations, various conceptualizations of homelessness, and methods of investigation.

Policy

Given the focus of most studies on one core issue or one stereotype of the homeless issue, policy suggestions tend to be truncated. Here, we attempted to develop a study in which a wider range of phenomena could be addressed. Behind our analysis is a three-fold division in the basic issues surrounding homelessness. We wish to discover:

> How to prevent homelessness. While much of the literature reports attempts to solve the problem of homelessness, once it occurs, it is equally plausible to look for ways of making sure that few individuals become homeless in the first place. At the most general level, this can mean looking at macro-level economic conditions that can help assure that all can at least afford a home. More narrowly, we can ask about what might happen when individuals are already in crisis, but not yet homeless. To what extent do, and can, a variety of services prevent the crisis from deteriorating into homelessness? This involves examining such issues as the availability of vouchered housing, money for security deposits, quick service in public welfare, or public and private emergency assistance for those who have just been evicted.

How to ameliorate homelessness. We wish to learn something about helping those who are homeless to cope with their condition--even though the range of needed data and the problems with assessment limit our investigation. Most directly, this is an issue of access to the basics of life: food and shelter. It also involves looking at health or social service problems, and how well they are met. Do the homeless make use of existing programs? Are there enough programs? Are certain groups served least well?

How to reverse homelessness. Much of policy analysis of homelessness focuses on the ways in which the homeless can be brought back into the mainstream. For those who have exited homelessness, is it their own efforts, those of service agencies, of friends or relatives? When something makes a difference, for whom does it work? Those who have problems escaping may demonstrate traits that make common paths less easy to use: can we compensate for this? Typical issues involve the use of family and friends, institutions, employment, public welfare, social services, and housing assistance.

Conceptual Scheme

There is no readily apparent, consistent, broad conceptual framework to help analyze policy issues surrounding homelessness. This is a serious problem because, without such a framework, it is difficult to determine exactly which questions to ask about the intricacies of homelessness, and thus to attempt to elucidate some policy suggestions. Nevertheless, we were able to focus this inquiry around some rather general hypotheses that were derived from the literature. We keep them simple, for now, but elaborate greatly in later chapters.

Basically, the major arguments surround the characteristics that lead to homelessness. For the sake of simplicity, these arguments may be divided into traits of individuals, and sometimes traits of the community. At each level, two schools of thought prevail.

First, some stress what might be called the purely economic factors. On the individual level, these involve a lack of "human capital" or the capacity to obtain employment. Education, work experience, and skills are examples of traits that involve human capital. From the point of view of the community, the level of unemployment or the general nature of opportunities must be considered. The basic argument is that the homeless are those who cannot afford housing because they cannot obtain employment or because housing costs are too high (Hopper and Hamburg, 1984). Second, alternate views stress other individual problems that make it more difficult to grasp opportunities. Some focus on what can be called "pathologies," such as mental illness or alcoholism. In addition, the traditional literature over the 1950s to the 1970s often emphasized "alienation," defined as a somewhat willing desire to disengage from the social order, perhaps caused by pathologies (Bogue, 1963; Bahr, 1973; Bahr and Caplow, 1974). On the community level, family structures, attitudes toward alcohol, social services, and so on, may affect the presence of such traits. In this instance, homelessness occurs either because individuals who need help refuse it, or when, due to pathologies, individuals are unable to garner the resources needed to afford or maintain housing.

We also move beyond these approaches and suggest that all these possible traits of individuals work through their interactions with the social system. Leaving aside the job market, homelessness might develop when some individuals cannot obtain resources from other social institutions. For example, homelessness might result more frequently when rents are high or apartments are not available. This might increase the probability of homelessness for everyone, but particularly for those who do not have resources for one of the reasons mentioned above. Or, limitations in the public welfare, social service, or mental health systems might result in a failure to prevent homelessness or to reverse homelessness, once it occurs.

One more distinction is between current characteristics and resources of individuals, and more distant resources. That is, individuals develop throughout their childhood some set of resources, or some level of pathology and alienation. How they make use of resources and express pathology depends upon their earlier interaction with social institutions. This early interaction affects their current resources, pathologies, and interactions with the social system. Thus, lifelong lack of skills and resources in some manner lead to immediate crisis, in which a lack of resources and skills result in homelessness.

Considering the body of literature on homeless, our scheme thus suggests testing the importance of a number of factors. We look, insofar as possible, at the role of the childhoods of individuals, and some of the traits derived from childhood. We consider how such traits affect economic status and life problems (alienation and pathology). We attempt to examine how all such traits might affect the interaction of individuals with social institutions (including the family, and the welfare system); the nature of these systems is also considered. Finally, we examine how all such factors affect the current behaviors of individuals and thus the potential for homelessness.

Methods

This perhaps overambitious design demands more than one method of inquiry. Indeed, one of the advantages of our design is that it involves both examination of the community, as well as a study of the homeless population.

Community Study

One part of the study is a community analysis. Its purpose is to overview the community resources that might, at least in theory, play a role in preventing, ameliorating, or reversing homelessness.

This component of the project involved reviewing studies of the institutional network. Information is available because many aspects of homelessness and poverty have been examined to some degree over the last six years. No single study utilizes our exact framework; but each can highlight certain issues. These studies vary from examinations of housing patterns to descriptions of patterns of shelter provision.

In addition, we carried out extensive interviews with a cross section of officials who are involved with many types of services. We attempted to determine what their agencies accomplished that might affect homelessness, and how services have changed over time. We also attempted to understand why agencies focus on certain services and what might determine this choice--funding agency priorities, community pressures, and so on. Specifically, we attempted to look at six types of services: income maintenance, shelters, mental health services, public social service, advocacy, and emergency assistance that might help forestall or avoid homelessness. Interviews with political actors and funding agencies also occurred. Approximately 70 interviews of one to one-and-one-half hours were conducted with about 90 officials. The interviews were based on six focused interview schedules that outlined the issues to be discussed. In addition, we searched records, census documents, and reports for whatever additional information was available.

The Survey

To gain a more detailed profile of the unique traits of the homeless, the study also involves a survey of the homeless and of a comparison group. As has been mentioned, the purpose of using the comparison group is to distinguish the traits of the very poor in general from the traits of the homeless.

The comparison group is a group of other individuals who have financial crises. This group is like the homeless in that they are very poor. Of course, the major difference is that the members of the comparison group have adapted in other ways and thus are not homeless. The data set thus is useful in answering questions about subtle differences between the homeless and other individuals with problems.

To develop a comparison group, we decided to make use of one sampling frame that included both the homeless and those who are not homeless. Comparison thus involves separating the homeless and the domiciled within one sample. This enables us to make comparisons with fewer concerns about representativeness and comparability of samples.

The sample for the Chicago study is thus a stratified, random sample of all adults who obtain the main meal of the day for free from service programs. This sample enables us to obtain a good cross-section of the homeless, because the vast majority of these individuals obtain free meals from a shelter or other service program. The other individuals who obtain free meals represent the comparison group. Clearly, this is a group that includes individuals who have at least one problem--the need, or at least perceived need--to obtain a free meal. They are likely to represent a reasonable cross-section of non-homeless but still highly needy individuals.

The involved programs are of three types:

--Shelters for the homeless that serve meals, which include the "transitional" (i.e., 30 to 120 days) facilities in Chicago.

--Meal programs, such as feeding sites, soup kitchens, or an occasional drop-in center at which individuals obtain the day's main meal. These facilities serve the homeless who are in overnight shelters in Chicago, many homeless individuals who are not in shelters, as well as domiciled, poor individuals. Programs specifically designed for the elderly were excluded.

--In-patient treatment programs that serve the indigent. The programs include some special mental health programs for the indigent, and some detoxification centers. But the vast majority of the programs are alcohol treatment programs for the indigent, such as Salvation Army programs.

This sample clearly includes a good representation of the homeless. It certainly includes those who use transitional shelters, one of the two shelter options that are generally available. Because the overnight shelters lead their clients to certain meal programs for the main meal, the sample includes homeless individuals who make use of these programs as well.

Treatment programs for the indigent also serve many who might be homeless when they are not in the program. As we will see, for some single men and women these facilities serve as their "transitional" shelters. In Chicago, there are about two-thirds as many individuals in such treatment programs as are in transitional shelters, and our analysis will point out that about half of them are homeless. Although very few studies have looked at individuals in such programs, we believe that it is important to include them in a sample that is meant to represent the broadest population of homeless. Indeed, a failure to include this type of facility, as is common in other studies, would lead to a gross underestimation of the number of those with drinking problems who are homeless.

Meal programs are sampled because previous studies suggest that the vast majority of homeless individuals who do not reside in shelters make use of meal programs (Roth et al., 1985). We thus have reason to believe that, by sampling from meal programs, we represent most of the non-sheltered group of the homeless.

Finally, the non-homeless group of our sample is comprised of individuals in treatment programs for the indigent who otherwise have a home, as well as domiciled individuals who make use of meal programs. Clearly, these individuals are generally also in some sort of financial crisis, although they have homes; they represent a useful comparison group.

The particular advantage of the sample is that it allows the traits of the homeless to be compared to the traits of other very poor individuals. It again should be stressed that the research design thus presumes that the homeless are among the very poor. It is designed to determine who among this group cannot maintain a home. As a result, the design can help determine if those factors often associated with homelessness have an impact above and beyond their impact on the likelihood of being very poor. Otherwise, traits of the entire sample can be compared to general population statistics to discern what is associated with such poverty. There are some instances in which the comparisons must be treated with more caution, and these will be noted.

Sampling Design

The sample is a stratified two-stage random sample. To develop it, the universe of programs was obtained from existing directories and from conversations with the major coordinating agencies for the programs in Chicago. The programs were then divided into three strata, comprised of the three types of sites (shelters, meal programs, treatment programs). Then, a sample of each type of site was randomly generated, giving the larger sites a proportionately higher probability of falling into the sample (size was estimated through telephone calls to heads of programs and through the use of a computerized count of the meal programs census).

Within each strata, a set number of individuals were expected to be interviewed per site (based on our estimates of how many individuals use the site each day; when more than one meal program served the same population, but split up the days of service, we included the programs as one, using the average number served each day to estimate the population). The number was set so that each individual at any site in the sample had the same probability of being interviewed. The establishment of identical sampling ratios across types of sites simplifies later statistical comparisons of the control group as opposed to the group of homeless individuals.

Sampling within sites was accomplished by as close to a random process as was possible. For shelters and treatment programs, randomization generally was accomplished with the help of a list of residents. (We generally used room numbers and not names in this process and in no cases recorded names of the respondents.) For meal programs, systematic sampling of individuals waiting in line for meals was used, randomly selecting the point in the line at which the procedure was begun. In all cases, only individuals who were randomly chosen were interviewed, and a careful count was kept of the number of refusals. All told, interviewers were sent to 28 different sites for this component of the study.

An early estimate of the sample suggested that there would be slightly too few homeless individuals for appropriate analysis. To increase our sample size, we sampled two other shelters, one other meal program, and one other treatment facility. Sampling was accomplished completely randomly and remained completely consistent with our previous design.

In theory, the added parts of the sample should be weighted differentially, because they were not selected to exactly keep to the sampling ratio, above. Nevertheless, when weights were calculated, differences between adopting no special weights and compensating for the added units were small; within each of the major strata (meal programs, treatment programs, shelters), no more than six more or fewer cases would be calculated due to weighting. Therefore, no weighting was attempted in this case.

We must stress that this sampling design has its limits. Obviously, it excludes those homeless individuals who never use programs, which may be a small number. But the comparison group includes only some very poor individuals--those who are in a crisis and use a meal program to help solve it. We feel that this was the most practical design available, but we will note its problems throughout the report. Other studies might do well to compare the results to those obtained by looking at broader comparison groups such as all those who live in poverty-level neighborhoods.

Questionnaires

The questionnaires covered the topics that are implied by the factors listed as relevant to homelessness. In brief, these varied from an examination of background traits to a look at mental health status, from a series of items about lifelong use of social services to some items about current use of services. When possible, individuals were asked about their specific interactions with such "various institutions" as the housing market or income maintenance agencies. Whenever this questioning was not possible, attitude questions that attempted to summarize past experiences were utilized. A typical interview took from 45 minutes to one hour to complete. Subjects were paid $5.00.

Interviewers

Interviewers include a large number of professional interviewers and a small number of graduate students from the School of Social Service Administration at The University of Chicago. They were trained by the director of the project and by one research assistant. Some interviewers spoke Spanish, and Spanish translations of the questionnaire were used where appropriate. The interviews took place over the Summer and Fall of 1986.

Response Rate

One shelter that appeared in our random sample refused to participate. This shelter was a small, transitional shelter that housed women with children. To avoid biasing our results against such individuals, we substituted another shelter. The substitution, accomplished through a random process, was with another unit having the same general characteristics. By chance, it was located in the same area of the city as the shelter that refused to participate.

Beyond this one incident, we experienced no great difficulties in completing the interviews. The response rate was quite high; 535 individuals were interviewed, representing 81.3 percent of those approached. This rate was similar across the three types of facilities: 82.2 percent for shelters, 82.3 percent for soup kitchens and other meal programs, and 79.5 percent for treatment programs. All but about one dozen respondents completed the entire interview, even though it was lengthy and relatively demanding. We should note that this rate of completion is much larger than many would expect, given stereotypes of the homeless.

Weighting of the Sample

The sample represents individuals who obtain the main meal of the day for free on a given day. But this might not equally represent all of those who are in a crisis. That is, it may very well be that individuals make use of the programs for only part of the time they are in need of a meal. This is problematic for the study. Those individuals in transitional shelters and treatment programs are available to be interviewed on nearly every day; but others might on occasion obtain food from elsewhere and might not be available on the day of the interview. Because the transitional shelters, in particular, focus very heavily on women and families with children, the bias can result in unrepresentative demographic traits when asking about all those who are likely to use free meal programs during a crisis, rather than when asking about the characteristics of those who obtain the main meal for free on a given day.

To compensate for this, the sample is weighted. For those in transitional shelters, we use the percentage of the time the individuals estimate that they can find shelter when they want it (78%) as the basis for weighting. The same figure is used for those in treatment programs. We returned to three meal programs to obtain the estimate of the proportion of days in a month individuals make use of a meal program: 58 percent. Because they use the facility less often, those individuals in a meal program are counted more heavily (weighted) than are the others in the sample. Weights are calculated so that the sample size remains approximately constant to its original size of 535. Because weights are calculated in fractions, however, the number of individuals responding to any given question, in weighted form, is not necessarily a whole number. Consequently, the numbers are rounded to the nearest whole number in all tables.

Definitional Problem

Nearly every study of the homeless faces a most difficult definitional decision about the nature of the group to be described. Some claim that, in its most narrow sense, the homeless are those who have no place to stay at all. This group includes those who live on the streets, in doorways, in train stations, or in other places that are not considered homes. In addition, this group generally includes those who live in shelters for the homeless. But it excludes individuals who live in a wide variety of other circumstances.

Some wish to include all of those who do not pay any rent in a definition of homelessness. If an individual is living somewhere for free, it is argued, that individual does not actually have a home. Individuals who are doubled up at relatives' houses may be homeless; so may those who live in treatment programs, if they are not paying for services, either directly or indirectly (through benefit programs, insurance, and so on).

Finally, some individuals are living in facilities in which they are vouchered or vendored. That is, a public or private agency is housing them by providing a voucher that they take to a hotel or motel, or by vendoring a provider. To some, this group may be homeless; to others it may not be.

We did not have a large sample of the last group of individuals; they simply were out of our sampling frame. Indeed, because such individuals are spread out across the city, with few in any one location, and are rare each night, we could not sample them directly. This is a shortcoming in our sample--and in most samples. One result is that our policy conclusions leave out this group. We believe most of these individuals are members of families with children, and judging from public and private agency figures, that they are homeless for short periods of time between stays at housing units. (In New York, we know, some members of this group remain in temporary housing for very long periods.) For Chicago, therefore, we are underestimating the short-term emergency cases and the need for special forms of assistance to deal with this group. Nevertheless, we believe that relatively few individuals are so vouchered each night.

In other cases, we attempted to create a definition that split the difference between the points of view. We define the homeless as:

> those currently residing for at least one day but for less than fourteen with a friend or relative, not paying rent, and not sure that the length of stay will surpass fourteen days;
>
> those current residing in a shelter, whether overnight or transitional;
>
> those currently without normal, acceptable shelter arrangements and thus sleeping on the street, in doorways, in abandoned buildings, in cars, in subway or bus stations, in alleys, and so forth;
>
> those residing in a treatment center for the indigent who have lived at the facility for less than 90 days and who claim that they have no place to go, when released. The 90 day limit is meant to make our definition consistent with that used for many shelters, because most transitional shelters, in theory, keep individuals only up to 90 days.

Please note that, among our shelters and treatment centers we include programs for battered women. While there are not a large number of such women included in our final sample, this is one difference from previous studies of Chicago.

OVERVIEW OF THE SAMPLE

As an introduction to the research, Tables 1.1 through 1.5 present some of the characteristics of the main sample.

Homelessness Status

One general stereotype of homelessness is that it is a long-term status. Individuals are said to fall into this state, and then develop additional pathologies that make exit nearly impossible. One thus might expect to find our sample to be comprised mostly of individuals who had been homeless for a long time and of those who have never been homeless. As Tables 1.1 and 1.2 suggest, however, a more complicated picture emerges.

Table 1.1

Homelessness and Interview Location
(Weighted)

	Percent (and number)			
	Currently Homeless	Previously Homeless	Never Homeless	Total
Shelter sub-sample	100.0	0	0	100.0
	(66)	(0)	(0)	(66)
Treatment program sub-sample	47.0	22.7	30.3	100.0
	(25)	(12)	(16)	(53)
Meal Program sub-sample	21.7	38.2	40.1	100.0
	(91)	(160)	(167)	(418)
(Total Number)	(181)	(172)	(183)	(536)
Total Percent of Sample	33.8	32.1	34.1	

Numbers and percents are rounded and thus sub-totals do not exactly sum to totals.

Table 1.2

Homelessness History

	Currently Homeless (n=181)	Not Currently Homeless (n=355)
Percent homeless before[1]	51.6% (n=179)	48.7% (n=353)
Days since first spell (if multiple spells)		
Mean	2947	3704
Median	1460 (n=91)	3285 (n=84)
Number of times homeless (percent of those homeless before)		
1	24.7%	46.2%
2-3	29.0%	33.7%
more than 3	46.4% (n=146)	20.1% (n=169)
Days since last spell started[2] (of all who have been homeless)		
Mean	755	1784
Median	90 (n=146)	730 (n=166)
Total days homeless[2]		
Mean	1093	630
Median	185 (n=146)	180 (n=156)

[1] Among the currently homeless are 25 residents of treatment facilities who we assume do not treat their current residence as a homeless spell.

[2] Treatment facility stays are added to the time homeless for those in such facilities who are homeless.

Numbers and percents are rounded.

As Table 1.1 suggests, currently homeless individuals represent about 33.8 percent of the sample, or 181 weighted individuals. They are 100 percent of those who are in the shelters, 47 percent of those individuals who are residing in treatment programs, and about 22 percent of the 418 (weighted) individuals who use meal programs. The proportion of those who use meal programs who are homeless is somewhat less than we anticipated; this seems to be due to the fact that the homeless tend to congregate near the meal programs in neighborhoods in which shelters are located (the only meal programs that many other surveys normally tap).

While those using shelters predominate among the currently homeless, other individuals are also represented. Fifteen of these homeless individuals planned to spend the next night with friends or with relatives; 22 expected to be sleeping on the "streets"; ten did not answer or stated that they did not know where they would sleep. The remainder were planning to spend the next night in a shelter or, in three cases, planned to return to their own homes.

Respondents were also asked whether they had been homeless before--although in this case we needed to rely on their own definition of homelessness. One surprising finding of the research is that a large number of those individuals who are not homeless now, have been in the past. These "previously homeless" individuals, as we call them, represent 32.1 percent of the weighted sample, or 172 individuals. The previously homeless group includes about 23 percent of those in treatment programs, and 38 percent of those who use meal programs. Thus, only 183 individuals, or about 34.1 percent of the sample, had never been homeless. Needless to say, our sample includes a much larger portion of the previously homeless than one might suspect. The "never homeless" group represents only 40 percent of all of those who use meal programs in the sample, and 30 percent of those in treatment programs for the indigent.

Table 1.2 reports some statistics on the history of homelessness among the sample members. It compares the history of homelessness for those who are currently homeless and for those who have been homeless, in the past, but who are not currently homeless--the "previously homeless."

Among the currently homeless, about 52 percent had been homeless, in the past. That is, the current spell of homelessness is not their first. For this repeater group, the first episode of homelessness occurred 8.1 years ago on average. The median is four years ago. Homelessness clearly was not continuous; roughly 46 percent of the repeaters report that they had been homeless more than three times. For the entire group of the currently homeless, the average length of continuous homelessness averages about two years. Clearly, the distribution is skewed; the median time homeless, that is, the continuous period for which half of the currently homeless have been without a place to stay, is only 90 days. Roughly two-thirds of the sample has been homeless for less than one year. For the entire group of the currently homeless--repeaters and first timers--the total time spent homeless has been about 3 years on average, but only one half year according to the median.

The picture is not all that different for the previously homeless (see Table 1.2) who represent about 49 percent of all those who are not homeless at present. For everyone in this group who had multiple spells, the first episode of homelessness occurred 10.1 years ago on average, or 9 years ago according to the median. Nearly half of this sample has only been homeless once before, one-third has been homeless two or three times, while about 20 percent has been homeless more than three times. For those with one spell of homelessness, this spell began approximately 4.9 years ago, on average, but two years ago, according to the median. The total time spent homeless is estimated by all previously homeless respondents to average 1.7 years, although the median stands at half of a year.

We cannot know if those who had been homeless in the past will again enter this state. But their dramatic, previous history of homelessness--which is basically similar to the history of homelessness among the currently homeless--suggests that such individuals may still be vulnerable.

The existence of a large group of previously homeless individuals who still make use of meal programs suggests the need for consideration of the "near" homeless in policy. That is, there appears to be a sizeable group of individuals who, while not currently homeless, have been homeless and continue to be in some type of crisis. In our sample this group is almost as large as is the group that is currently homeless. Given that those with a history of homelessness represent about half of all of those in the sample who are currently domiciled, perhaps there is generally a good deal of overlap between the very poor and the homeless.

Another implication is that homelessness is a repeated state for many. That is, while other studies have often claimed that homelessness is permanent, and that the amount of time an individual is currently homeless can be a proxy for the total time the individual had been homeless in a lifetime, this does not appear to be the case. True, about half of the homeless are in their first period of homelessness. But many other individuals in our sample have often been homeless repeatedly over a period of many years.

They seem to have a place to stay slightly more frequently than they do not; but many seem to be threatened with homelessness much of the time. This again suggests much interplay between the group of very poor individuals in the sample, in general, and the homeless. It may also indicate the importance of preventing spells of homelessness, which do seem to occur periodically for some individuals.

Finally, we conclude from the median time homeless and from the existence of multiple spells that, at present, many spells may be of moderate duration. To be sure, we do not know how long such individuals who are homeless will remain so; but given the history of repeated spells over a period of years, one would guess that the vast majority of individuals do escape, at least temporarily, for some interval. As much of a problem as helping individuals exit from homelessness are the issues of improving the stability of exits, and avoiding the probability of returns to homelessness.

Demographic Characteristics

Tables 1.3, 1.4, and 1.5 present some demographic characteristics of the sample as a whole and of groups with different experiences with homelessness. First looking at the overall pattern, the most typical age group involves those between 26 and 40, who comprise roughly half of the weighted sample. The 41-55 age group comprises 21 percent of the sample, and is roughly equal in size to the group that is under 26. Only 12 percent of the sample is over 55 years old.

Even taking into account the fact that only adults are surveyed, this sample is unusual in its age composition compared to the city, as a whole. According to the 1980 census, roughly 21 percent of Chicago adults are aged

Table 1.3

Sample Age Distribution
(Weighted)

Age	Percent (and number)			
	Total Sample	Currently Homeless	Previously Homeless	Never Homeless
Under 25	17.0 (90)	19.0 (34)	10.7 (18)	21.3 (39)
26-40	49.1 (260)	50.1 (89)	47.5 (80)	49.5 (90)
41-55	21.6 (114)	21.4 (38)	28.5 (48)	15.4 (28)
56-70	11.0 (58)	9.5 (17)	12.7 (22)	10.8 (20)
Over 70	1.2 (6)	0 (0)	0.6 (1)	3.0 (5)
Mean Age	37.6	36.1	39.7	37.1
(n)	(528)	(178)	(170)	(181)

Note: Total does not add up to sub-totals due to rounding the weighted frequencies.

Table 1.4

Sample Ethnic Distribution

	Percent (and number)			
Ethnicity	Total Sample (n=527)	Currently Homeless (n=175)	Previously Homeless (n=169)	Never Homeless (n=182)
Black	69.2 (365)	62.7 (110)	71.6 (121)	73.4 (134)
White	19.4 (102)	25.1 (44)	17.1 (29)	16.1 (29)
Hispanic	9.2 (49)	8.6 (15)	9.0 (15)	10.1 (18)
Mixed or other	2.1 (11)	3.7 (6)	2.4 (4)	0.44 (1)

Numbers and percents are rounded.

$X^2 = 10.787$ (N.S.)

Table 1.5

Sample Sex Distribution

	Percent (and number)			
Sex	Total Sample (n=530)	Currently Homeless (n=178)	Previously Homeless (n=171)	Never Homeless (n=182)
Male	70.2 (372)	63.2 (113)	83.4 (142)	64.6 (118)
Female	29.8 (158)	36.8 (66)	28.4 (28)	35.4 (64)

Numbers and percents are rounded.

X2 = 21.115 p < .01

25 years or younger, 28 percent are between 26 and 40, 22 percent a_e between 41 and 55, while 29 percent are older than this. The major differences are an overrepresentation in the sample of those between ages 26 and 40, and an underrepresentation of the elderly.

Table 1.4 presents the ethnic composition of the groups. Overall, the sample is mostly black, at 69 percent. Whites are the second most common group, representing 19.4 percent, while Hispanics represent 9.2 percent of the sample. There is no significant representation from any other group.

This sample is clearly more heavily oriented toward members of minority groups than is the population of Chicago, as a whole. According to 1980 census figures, Chicago was 50.3 percent white, 39.8 percent black, and 14.1 percent Hispanic. But a large concentration of minority groups among the poor is not particularly unexpected.

Insofar as gender is concerned, the population is predominantly male, at 70 percent. Among those who make use of these programs, therefore, men outnumber women by over two to one. This may be partly a function of the fact that many women retain the custody of children when relationships end, and also, if poor, are likely to receive AFDC. Because AFDC is more reliable (as we will detail below) than General Assistance, women are not as heavily represented among those in crisis.

One question is how the demographic traits vary by homelessness status. We thus divided the sample into three groups: the currently homeless, the previously homeless, and the never homeless. The tables report the demographic traits of each group, separately.

The differences in average age among the groups is rather small. That is, for the currently homeless the average age is 36.1. It is 39.7 for those who have been homeless in the past, and 37.1 for those who have never been homeless.

Nevertheless, it would seem that those who were previously homeless are the least likely to be under age 26 and the most likely to be in the 41 to 55 years old group. It is not surprising, however, to find that those who already had the life experience of homelessness and then an escape from it were slightly older than those to whom entrance and exit have not necessarily occurred. Of the small number of elderly individuals, almost none are among the currently homeless.

When ethnic group comparisons across the three groups are considered, differences are also small. To be sure, despite the fact that a majority of all groups is black, the currently homeless individuals are more likely to be white and less likely to be black than are members of either of the other two groups. Those with no history of homelessness are slightly more likely to be Hispanic. When the entire table is examined for statistically significant differences, the chi-square test suggests that the overall differences are not statistically significant at the .05 level that is used throughout this report. But as will be noted in later chapters, specific comparisons yield some statistically significant differences.

Table 1.5 reports the gender of the members of the three groups. There are quite large differences by group, and the differences among the three homelessness statuses are statistically significant. The main difference is that the previously homeless individuals are more often male, at 83 percent. The never and currently homeless are quite similar, 65 percent and 63 percent male, respectively.

This seems to suggest that those who are so poor that they must use meal programs are generally male. However, females, if they enter the status of the very poor, at all, are less likely to be in the previously homeless group. One possible explanation might be that women are now beginning to become homeless at greater rates, and thus are not yet significantly represented in the previously homeless group. But an equally likely explanation is that women who escape homelessness often escape to the degree in which they do not use meal programs. A very high proportion of such women have children; AFDC benefits and whatever help is obtained from relatives can be useful in escaping the crisis altogether.

IMPLICATIONS FOR RESEARCH

One prime research question is whether we can distinguish the homeless from other poor individuals. But the history of homelessness among many members of the sample suggests a dilemma for analysis. A comparison of the currently homeless to all others might be compromised by the presence of a large number of individuals in the comparison group who have experience with homelessness, even if they are currently domiciled. A comparison of those who have ever been homeless to the never homeless might, at times, also be inaccurate. For example, to study if the ability to garner welfare benefits predicts avoidance of homelessness, the ex-homeless, who may have escaped only after obtaining such benefits, certainly should not be categorized along with the currently homeless.

Accordingly, this study uses different comparisons for different purposes. When the concern is with factors or traits that we think are relatively stable, and thus that represent something about attributes individuals may have had before homelessness began, it is appropriate to compare those who have any homeless experience with those who have never been homeless. That is, information on background is most useful in understanding why some individuals ever become homeless, while other very poor individuals in crisis do not become homeless. The study thus often compares all of those who have ever been homeless with those who have had no experience of homelessness, particularly when examining factors that obviously preceded adult homelessness, such as demographic characteristics or childhood life patterns.

When the interest is in factors that can more easily change, we compare the currently homeless to those who are not currently homeless. This helps suggest whether there are any specific, immediate life circumstances that might be associated with the current state of homelessness. Typical traits that might differentiate the currently homeless from all others include current access to social services or current working patterns. When the causal chain seems to be more complicated, we occasionally will use both types of comparisons, or resort to analyses that combine the two issues. In all cases, we present both traits of the overall sample, and also the comparisons of the groups on such traits.

It should be noted that comparisons are generally based on self-reports. For such issues as drug or alcohol use, reports may be underestimates. But we compare subgroups to each other or to other self-report studies. In the comparison, biases should cancel out.

It also must be admitted that virtually any comparison is only a rough estimate of causality; the only precisely accurate approach would be to have access to longitudinal information on the entire sample, so that the exact timing of life circumstances and homelessness could be gauged. Even without this precision, we believe that the assumptions we make about causal direction are not particularly heavy-handed. In Chapter 6, more sophisticated, multivariate analyses will be presented in which different subgroups are compared to test some assumptions.

ORGANIZATION OF THE REPORT

In a general way, the organization of this report follows from the rudimentary theoretical framework we have mentioned, as well as from the desire to integrate information from a survey with information about the social institutions of the city. Chapter 2 overviews the general level of community resources and also the general economic and social traits of the homeless. It also looks at some institutions that cannot easily be separated from the general circumstances, such as the housing market.

Chapters 3 and 4 discuss, in some detail, the interaction of the population with two social institutions that are said to be of particular importance: the mental health system and the income maintenance system. Recent and lifelong experiences are considered and, insofar as is possible, are linked to differentiations among individuals on the one hand, and chances for homelessness on the other.

Chapter 5 looks at some of the institutions that are bound to the daily life of the homeless, such as the social service system and the shelter system. It also examines such factors as contemporary attitudes and lifestyles of the population that might be affected by, or affect, homelessness experience.

In each of these chapters, some attempt is made to determine whether given traits might be causally connected to homelessness--traits that vary from individual background to current attitudes. But the analyses are intentionally kept simple. Chapter 6 reports some multivariate techniques that are attempted in order to determine the causal chain that might lead to homelessness. Finally, Chapter 7 both presents an overview of the nature and causes of homelessness, and makes some suggestions for policy that are based on the analysis.

Chapter 2

General Economic Conditions, Social Structure, and Demographics

We have noted that, in searching for the causes of homelessness, individual researchers pay much attention to recent trends. Most agree that homelessness has increased over the course of the 1970s and 1980s. They search for causes of the increase among other factors that have changed, particularly among general economic or social factors (changes in services will be dealt with later).

However, if the inquiry were limited to only the most obvious of these changes, the increase in homelessness may appear to be something of a puzzle. Regardless of recent changes in earnings and in poverty rates, economic difficulties are probably on average no greater at present than they were in the 1960s, when homelessness appeared to be less common. While such supportive services as welfare benefits have clearly lost value over the last decade and a half, benefit levels nationally are still about what they were in the early 1960s. While the homeless are clearly poor, a straightforward causal chain from increased economic need to increased homelessness is not immediately apparent.

Accordingly, attention is often focused on apparently new factors, such as changes in the housing market or in family structure. As we shall see, however, some trends involving traditional measures of poverty are not as pronounced nationally but might be more problematic than they appear, when Chicago is considered separately. Some "new" trends may indeed also be important in understanding homelessness in Chicago, and perhaps nationwide.

TRENDS: POPULATION LEVEL

Census documents (these are not specifically cited in the text), other government publications, and other studies suggest the existence of local and national trends that might indeed contribute to the growth or at least the existence of homelessness. To be sure, information for Chicago trends with respect to each particular factor mentioned above could not be located, and even when there is some evidence, it often does not include trends all the way to 1986. But patterns are often clear.

Population Patterns

Homelessness might be more common when individuals have fewer personal or social resources to which to turn. While not all trends are negative, a large number of them suggest increased difficulties across the nation, with Chicago demonstrating even more problematic patterns. For example, there have been some notable changes in family structure in Chicago in the last decade. The average size of a family decreased during the 1970s from 2.9 to 2.7 in Chicago, and from 3.1 to 2.8 nationally. While this does not necessarily indicate decreased resources, the proportion of individuals who lived alone increased. It stood at 9.4 percent of the Chicago population in 1970, and at 12.7 percent of the Chicago population in 1980. National figures demonstrate a similar increase, but with proportionately one-third fewer individuals living alone. Although attributable, in part, to the growth of the proportion of the population that is elderly, almost two-thirds of the individuals who live alone are not elderly. Such single individuals, without family supports or eligibility for many federal income maintenance programs, might be most vulnerable to homelessness.

Equally important, there has been a dramatic increase in the proportion of one-parent families--families which might also be particularly vulnerable to economic distress, and perhaps to homelessness that is caused by such distress. Families headed by women, the census classification that comes closest to measuring the proportion of one-parent families, represented 18 percent of all Chicago families in 1970, but 27 percent of all families in 1980. This is much higher than national figures of 10.8 and 14.6 percent, respectively. Tellingly, only 44 percent of all children in Chicago lived in families with two parents in 1980.

Economic Patterns

Economically, Chicago experienced a marked decline over the decade of the 1970s, perhaps more serious than that of the nation as a whole. Perhaps like many central cities, Chicago lost almost 115,000 jobs in industry over the decade, and 152,000 jobs, overall. There was a modest growth in the service industry, but such jobs often tend to be at the lower end of the wage scale.

Accordingly, median income, which remained roughly constant nationally, actually fell by an inflation-adjusted 7.4 percent over the course of the decade of the 1970s in the city. The family poverty rate also increased from 12.2 percent to 16.8 percent--it stands about 6 percent higher than national figures. Perhaps more closely related to the dire poverty involved in homelessness, the number of individuals whose income represented less than 75 percent of the poverty line increased by 50 percent over the decade. Chicago thus has economic problems that are unusually serious.

Unemployment rates also increased in Chicago by an unusual amount. While unemployment stood at 4.4 percent in 1970, it was 8.9 percent in 1980. The unemployment rate increased dramatically in the early 1980s and remained over 9 percent in 1986, far above the national average of 6 to 7 percent each month. If national figures are a good estimate, long-term unemployment also generally increased (United States of America, 1987). The average duration of unemployment, 8.6 weeks in 1970, rose to 11.9 weeks in 1980. Despite claims of economic recovery, the average was higher in 1986 (15.0 weeks). In Chicago, the average duration of unemployment was an even higher 17.7 weeks in 1986. In other words, if homelessness occurs more frequently among individuals who cannot obtain employment and eventually run out of cash, there is evidence of economic conditions in Chicago and perhaps other urban areas that might be related to the increase.

Housing

At the most basic level, homelessness is a lack of housing; if some individuals are homeless, this seems to imply that housing is not available at the price at which some individuals can pay. It is not altogether simple to analyze the role of housing in homelessness, however. Unless the vacancy rate is near zero, there is some housing available. Thus, one can argue that the issue is whether individuals have the ability to afford existing housing. But once price is considered, it is quite difficult to distinguish problems in housing from income deficiencies.

The determination of availability of housing in the low income housing market is also fraught with perils. Even if all rents were known, along with all incomes, a perfect match of housing price to income is not to be expected. Not only do preferences vary, but so do the structures of families that might make use of them. A tight housing market thus can result in homelessness, in more "doubling up" or sharing of housing, or in some combination of the two.

Nevertheless, at a very general level there is some national-level evidence of a relative decline in housing availability at the lower end of the market, despite no general decline in the availability of housing. The average vacancy rate seems to have increased over the 1970s, but housing is coming to dominate an increased proportion of people's income. The increase is a larger proportion of income than might be expected on the basis of the near-stability of family income over the decade. Thus, the proportion of a family income going to housing (this includes utilities) nationally rose over the decade from 20 to 27 percent according to U.S. census figures. Moreover, among the very poor, the proportion of income going to payment of rent was quite high. Roughly one half of those with incomes of under $3,000 per year paid over 70 percent of their income for rent in 1980.

One cannot easily separate out all factors, such as the contribution of utilities or rent, in these increased costs. Nor can all reasons for any possible increase--such as competition with business, dilapidation, new housing construction methods, decreased family density, the lack of new public housing--be easily disentangled. But there is a clear increase in costs for the poor over the period. The best study, which at least controls for relative income (Brown and Yinger, 1986), suggests that 50 percent or more of family income was paid for housing by 33.64 percent of those in the lowest income group in 1974, but by 41.87 percent of those in the lowest income group in 1983; the proportion of all households which paid over 75 percent of their income for housing increased from 15.49 percent to 21.80 percent. Freeman and Hall (1986) argue that, between 1979 and 1983, there was only a one-tenth of one percent decrease in all housing units under an inflation adjusted $200 a month. However, for central cities, the decrease was 5.4 percent. The authors also note a decrease in an option that might be most common for single individuals, that is, the single rental room unit. These units tend to be located near the center of the city. This is true even though the number of such units decreased by only 0.9 percent, or about .97 million units, nationwide over the studied period; cities have special problems.

There is evidence of such decreasing availability of housing for the very poor in Chicago similar to decreases in other central cities. To be sure, the occupancy rate remained roughly stable over the decade of the 1970s, and even decreased to a small extent (from 94.2 percent to 93.1 percent of all housing units). Up until 1980, there also was little evidence that the very poor paid an increasing proportion of their income for rent.

However, for the very poor, more recent changes appear to be more problematic. For example, between 1979 and 1983, controlling for inflation as best as is possible with the use of published tables, it appears that there was a decrease of about 5.5 percent in the number of housing units renting for under $200 in 1983 dollars. The proportion of such units decreased from 17.1 percent of all units to 16.5 percent of all units. The proportion of households paying at least 60 percent of their income for rent increased from 13.6 percent to 22.2 percent over this period (U.S. Bureau of the Census, 1987, 1983).

Somewhat more detail about recent trends appears in a recently revised Chicago Department of Planning (1985) document that focused almost completely on housing that could be used by single individuals, and unsubsidized housing of this kind. To be sure, the report has been attacked for studying housing units with a rent ceiling of $300 a month, and for also considering individuals with incomes as high as twice the poverty line. Nevertheless, the study notes that, if one were to consider the common rule of thumb that individuals should use only one-fourth of their income for rent, the housing problem appears to be large. While the city has about 700,000 rental units, only about 70,000 rent for under $100 a month, the maximum that a family or individual with an income of $7,500 a year should pay. Yet the 1980 census revealed that 201,782 households had such an income.

By this income definition, there were 107,340 low income single individuals who rented separate dwelling units. There are also additional roomers or boarders, estimated at 5,000 to 15,000 individuals. On the average, incomes of all these single individuals are low; 80,000 had incomes of under $5,000 a year, while half of this group reporting incomes of under $3,000 a year.

This report further divided the sample by age. Thirty-three percent of the single individuals are between 35 and 65, 44 percent are older than this, and 23 percent are between ages 18 and 34. Perhaps surprisingly, in the middle-aged group, the majority--57 percent--were women. For seniors, about 32,000 live in low income subsidized housing; 16,000 have private housing. However, the average rent is about 34 percent of their income. Men are only one-third of this group.

Of the youngest group, which is generally close in age to many of the homeless, about one third of those with incomes below $5,000 pay rents of over $200 a month. Some of these may be students whose income is in a sense undercounted; some may be in dire financial straits. Clearly, the vast majority of the group pays more than one fourth of their income for rent, however.

Single room occupancy units (SROs)--or rooms with shared or private baths, no kitchens, an office and switchboard, with linens and some maid services--are said to be decreasing quickly in the city. There were about 22,000 units in 1970 but only 11,000 by the end of the decade. Many believe that the decreases account for the increase in homelessness. At present, however, SROs account for a minority of the places at which this population might live; only 13 percent. Of these units, 9,820 were occupied by low income single renters in 1980 (however, the census figures used to calculate this number are not precise). Senior citizens, 45 percent of the entire sample population, occupied 38 percent of these units. Rent averaged $57 a week in 1980, which is quite high for the population.

Apartments and rooming houses are much more common; such units, renting for $57 a week on average, account for 46 percent of the units for single individuals. The remaining units for single individuals apparently occur in the small buildings that were not studied in detail.

Putting all of these data together, the average rent in studied units is $255 per month. This is far beyond what many of those in the sample can pay. The study notes that 92,200 people can afford a rent, at most, at $156 a month; but only 92,781 such units exist in the city, and "most" of these are occupied by families and are thus not available to these single individuals. Even given the problem of the possible flexibility of family composition, a true lack of low cost housing is apparent.

Most important, the study concludes that there was a significant decline in the number of all such units from 1970 to 1984. This was estimated to be about 18,000 over the course of the decade. Clearly, such a decline can put pressure on individuals that might result in at least temporary homelessness caused by the lack of available housing at an affordable price.

In sum, there is evidence of increased cost of housing for those at the lower end of the income scale, and of a particular lack of availability of any housing for some individuals who live alone in Chicago. This could be linked to homelessness.

Effects of Doubling Up

The average size of families, and other similar figures, indicate that fewer individuals live in overcrowded housing units in 1980 compared to 1970, nationally. We could not locate more recent or more local figures. Even so, there is a perception that, among the very poor, the sharing of dwelling units is increasing. This is called a phenomenon of "doubling up," although the alleged increase may involve family members, two separate families, unrelated individuals, or some combination.

No matter what the trend is, it is clear that one must take into account the issue of shared dwelling units in an analysis of homelessness. For example, a study of General Assistance in Illinois reports that only one-third of those requesting such benefits lived alone at the time of application (Stagner and Richman, 1985). For those living with others, the mean household size was three. Only 11 percent of all such individuals were living with children.

At a follow-up interview one year later, the proportion living alone remained high, at 35 percent. The infusion of the rather limited general assistance benefits did not create any sudden changes.

Other evidence suggests that overcrowding and living alone are both linked to life problems. According to a study that made use of 1973 data from Chicago (Gove _et al_., 1983), those living in crowded units are unusually likely to have psychological symptoms in general, and a sense of normlessness, in particular; to have a poorer mental health balance, lower self esteem, and reduced levels of happiness. Perhaps such situations are inherently unstable; perhaps homelessness occurs when problems give rise to movement from an overcrowded unit to the street.

Those who are socially isolated also have problems. In particular, women who live only with their children and have few other contacts are most likely to be child abusers, and also likely to have children who do not achieve well in school. It is possible that, beyond income limits, such a life style gives rise to psychological problems that result in homelessness.

ALTERNATIVE EXPLANATIONS

This search for causes of homelessness should not overlook some of the more traditional explanations. Homelessness, even if tied in some way to general reductions in resources, might affect groups that have always been on the brink of homelessness, but simply might have an increased vulnerability due to such conditions.

Even though the evidence is not strong, some of the literature from the 1960s and 1970s also tied homelessness to what might be called "alienation." As Chapter 1 notes, the homeless were said to be those who have given up on mainstream society, and have instead chosen to identify with others who are unconventional (Bahr and Caplow, 1974). Homelessness was thus said to reflect a lack of such conventional ties as marriage or friendships. This traditional school of thought included the point that, for some, personal problems might give rise to alienation. In particular, "pathologies" such as alcoholism might be implicated in the decision to choose an unconventional life-style. More recently, researchers suggest a somewhat different possibility, that these pathologies make it unlikely that the homeless can obtain the cash needed to maintain a home or can live with others and share expenses.

While this is something of a stretch, there is a small amount of evidence of increases in pathologies, in particular, that might lead to homelessness. It is possible that homelessness occurs to those individuals who are unable to obtain, or make use of whatever resources are available. Perhaps alcoholics, drug addicts, or the mentally ill are most in danger; and at least for the first two of these, there is some evidence of increased problems nationally, particularly among the young (Human Services Research Institute, 1984).

The proportion of youth age 12 to 17 who ever tried marijuana or hashish grew from 14.0 in 1972 to 30.9 in 1979; cocaine use increased from 1.5 percent of this group to 5.4 percent; alcohol consumption from 54.0 percent in 1974 to 64.1 percent in 1979. For young adults, ages 18-25, a similar increase occurred. To be sure, consumption of certain drugs decreased slightly between 1979 and 1985; but there was a general upward trend over most of the period (National Institute on Drug Abuse, 1986).

Some of the above "pathologies," as well as the economic problems, might contribute to homelessness even if they are not increasing or do not account for changes in the rate of homelessness. Other important traits to consider include childhood dislocation or perhaps such adult crises as divorce or traumatic jail or prison experience. Each can lead to demoralization or to a lack of those resources that are needed to maintain a home.

Thus, placement in institutions can in part represent a pathology that later gives rise to homelessness; or, institutional placement might in itself cause a difficulty to arise, such as a lack of contact with families and friends, or personal disorganization. Each can reduce access to resources, and thus can contribute to homelessness. Another possibility is that those who have lived in such unconventional ways are more able to tolerate temporary homelessness as adults. Although it is clear that the vast majority of individuals who have been institutionalized do not become homeless, we will argue that experience with such facilities is surprisingly evident in homelessness.

The relation between institutional arrangements and homelessness might also include consideration of military service. While, for the vast majority of individuals, such service has no such effects, there is the possibility that a small proportion of individuals are scarred by service. This can be caused by everything from wartime mental or physical injuries to disaffiliation. There are those who claim that the Vietnam war, in particular, resulted in large scale disaffiliation.

SURVEY RESULTS

Naturally, there is a difference between stating and proving these arguments. For example, just because unemployment has increased, it does not necessarily follow that homelessness is a result of this increase. The homeless may be lifelong, poor individuals whose status is such that they would be homeless under almost any situation. The high rents may mean that many are hungry or double up, but these individuals do not necessarily become homeless. Those with given pathologies may have many problems, but homelessness may not be one of them. The general evidence on trends cannot help understand homelessness unless it is combined with a working knowledge about the homeless.

The survey data is in part designed to develop the potential ties between general characteristics of the community and specific issues involving homelessness. To be sure, because the survey only includes point in time data, the statistical investigation cannot directly link long-term patterns of homelessness to long-term patterns of community characteristics. Rather, the investigation considers what the characteristics of the homeless might be, and attempts to use the above as part of the framework to understand such characteristics. In general terms, this chapter thus looks at the first portions of the causal chain chapter one briefly described: the nature of childhood and relatively constant traits of individuals, the nature of the social institutions represented by the economy and housing market, and their relation to homelessness.

THOSE WHO HAVE EVER BEEN HOMELESS

One general issue is whether those who have been homeless differ in background from the non-homeless. Both groups may have similar problems in finding employment that simply reflect a lack of education or job skills; the homeless may have different traits that indicate special problems; or both groups might have peculiar problems.

The comparison of the never and ever homeless is the most appropriate in using the survey data to obtain evidence on this point. That is, we are concerned with whatever background characteristics lead to homelessness experience; if we did not include the group that is not currently homeless but had been so in the past, then we would simply be comparing the currently homeless to a second group that also includes individuals with homelessness experience.

Economic Background

To begin the analysis, Table 2.1 reports some of the basic personal background and demographic traits of the entire sample. It also compares the ever and never homeless on the traits.

Demographic Characteristics. The first few entries on Table 2.1 compare the ever and never homeless groups on demographic characteristics: age, ethnicity, and gender. Because overall sample characteristics have been mentioned in Chapter 1, we will focus on differences among groups and will not discuss the nature of the entire sample compared to the population of Chicago.

The table suggests that the two groups are nearly identical in the average age. The percent of the sample that is black is somewhat higher for

Table 2.1

Selected Background Characteristics of the Ever and Never Homeless (Number of Respondents)

	Among Total Sample	Among Those Ever Homeless	Among Those Never Homeless
Demographics			
Average Age	37.6 (528)	37.8 (347)	37.1 (181)
Percent Black	69.2 (527)	67.0 (344)	73.4 (182)
Percent Male	70.2 (532)	73.1 (349)	64.6* (182)
Economic Background			
Parental Income Scale (1=high; 6=low)	3.59 (520)	3.56 (339)	3.67 (181)
Highest Individual Income, 1977 Dollars			
Mean	$233.71	$236.37	$228.23
Median	$169.01	$162.49	$180.28
Mean Year	1977 (445)	1977 (300)	1977 (145)
Highest Family Income, 1977 Dollars			
Mean	$491.23	$507.21	$466.78
Median	$302.27	$300.50	$307.13
Mean Year	1973 (305)	1973 (210)	1973 (95)
Percent of Adult Life Worked	51.4 (536)	52.0 (353)	50.3 (183)
Average Years of Education	10.9 (529)	11.0 (348)	10.9 (181)

Numbers and percents are rounded.

For ever homeless and never homeless comparison:

* $p < .05$
** $p < .01$

those who have never been homeless than for the ever homeless, but the difference is small and not statistically significant. The three-way breakdown in Chapter 1 suggests further breakdowns by various ethnic groups, and also demonstrates few differences.

Those who have ever been homeless are a bit more likely to be male, but this result is a bit misleading: those who have never been homeless and those who are currently homeless have a similar sex distribution. The major difference is that the previously homeless group is very likely to be male. As was mentioned previously, it is likely that when escaping homelessness, more women (particularly those with children) also escape the crisis as measured by the use of the meal programs.

Family and Personal Background. Table 2.1 also reports information on some other economic background factors, from childhood and adulthood. A first issue is whether family poverty might breed some sort of cycle of poverty, of which homelessness is one manifestation. The collected data did not include objective information on family income when the individual was a child; memories of parental income are known to be very inaccurate. Instead, the respondents were asked to estimate the general economic circumstances of the family.

While all details are not reported on the table in weighted format, the modal response from the sample was that their family had "average" income. This response was given by 42 percent of all respondents. Only 1 percent claimed to be from a wealthy family, and 19 percent claimed to be from a family with an above average income. Roughly 30 percent reported an income somewhere below average.

It is always difficult to judge precisely what respondents mean by replies to such a scale; we did not have access to population characteristics on this variable. In any case, the most important question is whether the homeless differ in background from those who have never been homeless. Ironically, Table 2.1 reports that those with a homelessness experience tend to claim for themselves a somewhat higher status as a child. But the differences are small; they do not reach statistical significance at the .05 level. The best conclusion is that, among the very poor, those with homeless experience report a similar economic background than do others.

Individual Economic Background. Some researchers claim that the homeless are those who have "fallen" from the middle class into their status over the course of their lifetime; others claim that this group is more likely to be the long-term poor. To assess this issue, the members of the sample were asked about their highest income; that is, the highest income the individual ever received. At the same time, we looked at the highest reported income of the family since the individual had been an adult.

Table 2.1 reports the median and mean values. In calculating the mean, we deleted those nine individuals and families whose incomes were unusually high--greater than $60,000 a year for an individual and $90,000 a year for a family (in 1977 dollars). Without such exclusions, our results would be inaccurate and biased. For example, one individual claimed an annual income of one million dollars a year at one time, which clearly changes the mean figure greatly.

Using 1977 dollars in all cases to standardize earnings (these need to be multiplied by 1.77 to obtain 1985 dollar equivalents, for example), the largest individual income averaged about $234 a week. The median is about $169. On average, individuals claim that their highest income occurred 9.4 years before the interview, or approximately in 1977. At least for those who have been homeless multiple times, this is quite close to the point of the first instance of homelessness.

Clearly, such incomes are not unusually high. However, they are also not quite as low as one might think. For example, because 1977 was used as the year for standardizing income, it is useful to compare the above numbers to 1977 income figures for the national population. The median individual income reported for black males, nationally, in 1977 was $6,483 per year, which is about $124.67 per week. For full-time minority workers, which is perhaps the more appropriate comparison, the median was $11,037 per year, or $212.25 per week. To be sure, if we compare the best income of our sample members to a typical income for a full-time worker, the incomes were below average, but incomes typically were above the poverty level and roughly comparable to those for black males.

Nevertheless, these incomes certainly were below those for the more advantaged white workers whose median income was $324.79 per week for all workers, and $471.06 per week for full-time workers in 1977. By this standard, the very poor in our sample had always been disadvantaged.

Family incomes have a similar pattern: they tend to be low but are above the poverty level. The highest mean income occurred on average in 1973, and averaged $491.23 a week; the median was much lower, however, at about $302. However, small numbers reported their family income--only 305 individuals. We suspect that some did not know incomes of other adults with whom they lived; some single individuals simply did not consider themselves to be a "family" and did not report this.

There is also little evidence of lifetime unemployment, as only seventeen members of the entire sample say that they had never worked. Typically, an individual reports starting work at age 16, and the typical individual claims to have worked, on and off, roughly one half of the time since their sixteenth birthday. This is a picture of a great deal of sporadic unemployment, but it is not a picture of a total lack of work. The very poor comprise individuals who can work, or at least have worked at one point.

Not all of this work is recent. As will be noted in Chapter 5, roughly 30 percent of the sample is currently employed. For the rest, on average, the individual left the last job 4.2 years ago; the median is 1.3 years ago. One fourth of this group that does not work has not worked for about six years--again, this is shorter than the average time since individuals first became homeless, indicating that homelessness did not always signal an end to work.

One reason for this lack of steady employment might be education. Even adding general education degrees to high school graduates, the typical member of the sample went only to the eleventh grade. Only 53.8 percent graduated from high school or were more highly educated. Very few members of the sample (2.3%) had a college degree.

How do those with homeless experience differ from others on these measures? Looking at standard 1977 dollars, the highest individual income is not very different and certainly is not different enough to reach statistical significance. The median stands at about $180 per week for those who have never been homeless, and at about $162 for those who have been homeless. The means are even closer, at $236 and $228, respectively (see Table 2.1). The family incomes of the two groups are also comparable.

The work histories of those who have been homeless also demonstrate little difference from the history of those who have not been homeless. Those with a background of homelessness and those who do not have such a background estimate working a similar proportion of the time since obtaining a job, somewhere over one-half the time. Both groups can, and have worked; and both groups have a history of low-paying jobs and of periods of unemployment. This lack of continuous work is a characteristic of the entire sample but not of the homeless in particular.

This is also true for education. Those with a history of homelessness have a slightly higher level of education. But the difference is so small that it is virtually meaningless.

Even though homelessness is thus not specifically tied to a lower lifetime record of earnings or work within this sample, it must be stressed that this evidence does not imply that the homelessness is independent of economic background. Both those with homelessness experience and those without it have a history of intermittent employment and have below average levels of education. Lower than average incomes and sporadic work histories must indicate some probability of falling into homelessness at one point in time. Economically, the homeless are simply a sub-set of the very poor, with a quite similar economic history.

Personal Background

Those with experience of homelessness might differ in other background characteristics that would make homelessness a more likely outcome. These might, for example, involve lifetime isolation from others, or a life experience that makes homelessness more acceptable. Comparisons on these and other issues are presented on Tables 2.2 and 2.3.

Institutional History. Some traditional literature suggests that institutional experiences might result in an alienation from society. In keeping with this literature, members of the sample were also asked about whether they had experienced any out-of-home care as a child in one of three possible locations: foster care, group care, or any other child care institution. They were also asked about experience with military service. Both types of institutional experiences have been claimed to lead to alienation from society for a few individuals, from which homelessness might follow. (Information on mental health commitments will be considered in Chapter 3.)

Looking at the entire group, the proportion of the sample with some institutional experience is high. Roughly 12 percent of the entire sample experienced out-of-home care. While national averages could not be located, experts we contacted suggested that 2 or 3 percent of the adult population, in general, might have experienced such out-of-home care. From our sample, we must conclude that the very poor in general are unusually likely, at one time or another, to be cared for by a formal agency rather than by their parents or other relatives.

The history of military service does not appear particularly high for a sample of individuals between 25 and 40 years old, and 70 percent male. Roughly 23 percent of the entire sample had military experience. According to the United States 1980 Census, about 33 percent of Illinois males and 1 percent females who were over the age of 15 had served in the military.

Table 2.2

Institutional History, Marital History and Family Structure of the Ever and Never Homeless (Number of Respondents)

	Among Total Sample	Among the Ever Homeless	Among the Never Homeless
Institutional History			
Percent ever in childhood out of home care	12.0	14.5	7.2*
	(530)	(348)	(182)
Percent ever in military	22.9	26.4	16.1**
	(531)	(349)	(182)
Marital History			
Percent who were ever married	44.8	43.8	46.6
	(531)	(348)	(182)
Percent who had their own children	66.8	66.9	66.6
	(529)	(346)	(182)
Percent still married	9.0	5.0	16.4**
	(529)	(346)	(182)
Household Arrangements			
Intact family household	7.2	3.7	14.0**
Childless couple household	1.9	0.7	4.5**
Woman with children, no husband	15.5	15.7	15.3
Man with children, no wife	2.3	1.3	4.3*
Household with other relatives	17.6	7.7	37.2**
Single-person household	52.6	65.6	27.1**
	(501)	(332)	(169)

Numbers and percents are rounded.

For ever homeless and never homeless comparison:

* $p < .05$
** $p < .01$

Table 2.3

Other Attributes of the Ever and Never Homeless (Number of Respondents)

	Among Total Sample	Among the Ever Homeless	Among the Never Homeless
Percent with prison experience	12.6	14.0	10.1
	(523)	(344)	(179)
Percent with jail experience	57.2	65.0	42.2**
	(521)	(342)	(179)
Percent who consumed any alcohol in last 30 days	58.1	60.6	53.3
	(524)	(345)	(179)
Average standard units consumed in 30 days	65.3	68.3	59.7
	(523)	(344)	(179)
Alcoholism scale score:			
0 to 4	0.40	0.48	0.26**
Percent with any symptom	20.2	23.4	14.0*
	(524)	(345)	(179)
Percent of sample who go on drinking binges	17.6	21.6	9.9**
	(534)	(357)	(182)
Percent who use illegal drugs	15.5	15.8	15.4
	(523)	(345)	(178)
Of above percent using:			
speed or downers	12.0	14.1	7.9
	(81)	(53)	(27)
cocaine	42.1	46.4	33.6
	(81)	(53)	(27)
heroin	30.1	33.9	22.8
	(81)	(53)	(27)
other opiates	5.4	2.0	11.9
	(81)	(53)	(27)
psychedelics	7.7	7.6	7.9
	(81)	(53)	(27)
marijuana	64.6	56.1	81.2*
	(81)	(53)	(27)
sniffing paint/glue	1.3	0.0	4.0
	(81)	(53)	(27)
others	2.7	4.1	0.0
	(81)	(53)	(27)

Numbers and percents are rounded.

For ever homeless and never homeless comparison:
* $p < .05$
** $p < .01$

Using the averages as a rather rough guide, one would expect military experience in our sample to involve about 24 percent of the subjects.

Some individuals experienced peace time service, some wartime service. In general, 15.5 percent of those who had served were in the military during World War II, 20.0 percent during the Korean War, and 31.0 percent during the Vietnam conflict.

When comparisons are analyzed, it is perhaps surprising that there are differences on these traits between those who have been homeless and those who have not been homeless. Those with a history of homelessness are twice as likely to have been in one of these out-of-home institutions as a child; this difference is statistically significant. Those with a history of homelessness are also more likely to have experienced military service, and the relation is statistically significant. Fully one-fourth of this group has served, while only 17 percent of those without a history of homelessness served. This difference appears despite the similar demographics of the two groups.

The result involving the military, in particular, must be treated with caution. Some might believe that it is consistent with the claim that Vietnam experiences caused particular problems for some members of the military. Given the average age of the sample, however, military experience is not necessarily limited to the latest conflict. In fact, those who served, but have been homeless, are less likely than others who have served to have served during Vietnam, and equally likely to have served during World War II or the Korean War. One might thus guess that the difference, instead of indicating that problematic wartime experience leads to alienation from society, suggests that some of those with military experience may have enlisted because of other differences that make homelessness more likely. Indeed, evidence that will be reported later in this chapter and also in Chapter 6 suggests that both military service and out-of-home care are in part important because of their relation to the inability of the homeless to live with relatives other than spouses and children.

Marital and Parenting History. One claim that emanates from the 1960s or earlier is that homelessness is highly related to lifelong isolation from family as well as to a history of institutionalization. The homeless, it has been noted, are not likely to marry; they also are likely to be alone when homeless. It may be that isolation is a cause of a rejection of a life style, and that homelessness is one outcome of this rejection. Relevant comparisons are reported on Table 2.2.

Among our entire sample, there is something of an underrepresentation of the married compared to what is the case for a typical cross-section of adults. For the Chicago metropolitan area in 1980, 67 percent of adult males and 74 percent of adult females have married. However, close to half of our sample (44.8%), had been married at one time. This is low for a group with an average age of 38, but certainly is not as low as others might suggest.

Nevertheless, there is more of a history of parenting than of marriage. Two-thirds of the sample have children of their own. The average number of children is 2.7 among those who have had children--although most individuals who have children claim to have two children or fewer (not reported in Table 2.2). While we did not have access to national or local figures, one would imagine that this proportion of child-bearing is indeed low, suggesting that the economic problems of the sample lead to delays of marriage and decisions to avoid children in some cases.

Lower percentages of the sample are currently married. Only 9 percent is in this status, compared to 56 percent of males and 51 percent of all adult females in the Chicago area. About 25 percent of sample members are living with their children. The alienation from children is particularly common among males, of whom only 8.8 percent have custody of children, even though 58.7 percent fathered children. Of females, 61.3 percent have custody of children, while 86.5 percent have had children. Indeed, this pattern seems to be reminiscent of recent discussions of the "underclass," represented by women who have custody of children and men who do not fulfill their family obligations. In some ways, our entire sample seems to consist of many individuals who others have called members of this underclass.

Some other useful findings emerge when considering those who are not members of conventional families. As Table 2.2 notes, 17.6 percent of the sample define their household as one that also includes other relatives--perhaps parents, uncles, aunts, and so on. Most impressively, 52.6 percent of the sample represents a one-person household by their own definition. As national studies of the homeless suggest, members of our sample tend to live in independent households with unusual frequency. (This proportion of households that are one-person households in the city is 31 percent of all households according to the 1980 census; note that this is higher than figures based on individuals, but comparisons of households may be more appropriate given our sampling frame which tends to include only one individual per household and does not interview children.)

These patterns of marriage, divorce, and alienation from children among males are not atypical of studies of the homeless carried out in any era from the 1960s to be present. Interestingly, however, the pattern of family formation is not related to homelessness status. That is, there is a strong similarity in the experience with marriage among those who have been homeless and those who have not. About 44 percent of those experiencing homelessness and 47 percent of those who have not been homeless have been married at least at one time. Roughly two-thirds of each also has children. There is no particular pattern of lifelong isolation among the homeless in this data.

There is a rather strong relation between homelessness and current family patterns, however. While 35 percent of those who have never been homeless remain married, this is true for only 12 percent of those who have had some experience with homelessness. And while 13 percent of the homeless remain in households in intact families, the figure is only 3 percent for the currently homeless. Both of these differences are statistically significant.

The two groups do not greatly differ in the extent to which females head families: 16 percent of those interviewed individuals who had homelessness experience fall into this category compared to 21 percent of the never homeless. Neither figure differs greatly from the proportion of all Chicago families that are headed by one parent (mentioned earlier in this chapter).

There are also quite strong differences in the proportion living with relatives. Only 7.7 percent of those who have ever been homeless consider other relatives as part of their household; among those with no such history, relatives are considered part of their household 37.2 percent of the time. Nearly two-thirds of those with some experience of homelessness consider their household to be a one-person household, while this is true for only 27.1 percent of those without any such experience. Differences are statistically significant.

We must conclude that the relation of a lack of family ties to homelessness is much more complicated than most have claimed. While the very poor individuals in our sample were unusually unlikely to have ever been married, marriage does not distinguish the homeless from those without homeless experience. One might guess that the low levels of marriage reflect extreme poverty in general and not homelessness in particular.

However, there is a high rate of family dissolution among those with a history of homelessness. One reason might be that family disruption is one indicator of the nature of personal disorganization that might precede homelessness. As we shall see later, however, a very likely explanation is simply economic; when individuals no longer have other individuals to share housing, they cannot as easily overcome financial crises. Even with a similar history of income or work, they are more likely to become homeless due to the lack of such ties. Chapter 6 presents some of the confirming evidence on this point.

On the other hand, those women with children who still have custody are nearly equally represented in both the ever and never homelessness group, and in fact are slightly underrepresented compared to the proportion of such households in Chicago, as a whole. It seems likely that, despite the trauma of homelessness, most of those women who have had custody of children retain it. For women with children, we suspect, factors that might lead to or help avoid homelessness are both powerful. The women may be able to avoid homelessness due to the presence of AFDC benefits; but as Chapter 4 notes, if they lose benefits, the cost of maintaining children can drive them into homelessness.

Other Personal Characteristics. There are some characteristics that might contribute to homelessness but also that might be a result of it. In particular, those who consider pathology a cause of homelessness suggest that alcohol consumption or drug use might relate to homelessness; others focus on the criminal history of this group. There also is the claim that homelessness is a cause, rather than an effect, of such traits. Therefore, what to conclude from these comparisons is more questionable. Nevertheless, Table 2.3 presents a few selected comparisons for the never and ever homeless. Once again, we report results from the overall sample and also for the comparison groups.

Even though population norms could not be gathered, the figures seem to suggest that the entire sample is unusually likely to experience jail and prison experience. Jail experience is common for well over a majority of the sample, or 57 percent. Further, roughly 11 percent had some prison experience.

At least as a rough indicator of the relation of alcohol consumption to homelessness, Table 2.3 reports an analysis that compares use in the two groups on four measures:

a. the proportion that claims to have consumed any alcohol in the 30 days preceding the interview;

b. the reported average alcohol consumption of the groups in the same 30 day period, which totals separate questions about consumption of beer, wine, and hard liquor and standardizes drinks into "absolute" ounces of alcohol;

c. the proportion of the sample members who admit to going on drinking binges, that is, periods in which they drink much more heavily than usual; and

d. the scores on a five point scale that represents symptoms of late-stage alcoholism (whether individuals have no symptoms, coded as zero, and an additive scale of whether individuals report having blackouts, passing out, having shaking and tremors, and having seizures).

As the table notes, only slightly more than half, or 58 percent of the sample, claim that they drank at all in the past thirty days. On average, an individual consumes about 65 standard ounces of alcohol per month, which averages to about two ounces, per day. The median is 3 ounces per month. However, when those who do not drink, at all, are excluded, the median is 36 standard drinks per month. Clearly, by no such measures are a majority of individuals able to be categorized as heavy drinkers.

Nevertheless, there are a good number of individuals who appear to have drinking problems. The typical score on the four-point scale of late-stage alcoholism was only 0.40. However, about 106 weighted responses, or 20.3 percent of the sample, have at least one such symptom. This is a perhaps low estimate of the proportion of the sample who might be alcoholics.

Similarly, 17.6 percent of the entire sample claims to drink on periodic binges. Binge drinking is highly correlated with the alcoholism scale for the entire sample (r=.67). Both scales seem to measure alcoholism.

The table also reports responses to some selected questions concerning drug use. While responses may be biased downward, only about 15.5 percent of the respondents in the overall sample claim to use illegal drugs. Of those who use drugs, about two-thirds claim that they use marijuana, while over 40 percent claim to use cocaine. A perhaps disturbing 30 percent of drug users--slightly under five percent of the entire sample--claim to use heroin. Otherwise, drug use appears to be slight.

The basic conclusion about drinking and drug use in the entire sample is that the typical respondent seems to be less likely to so indulge as compared to a national sample--perhaps because drinking or drug use demands cash. However, a somewhat greater proportion than is true in the population as a whole seem to have a problem with drinking or with drugs. Thus, a 1985 national study of young adults (Johnston et al., 1985) suggests that 76.4 percent consumed some alcohol in the last 30 days, which is higher than the proportion we report here. But a small proportion, 6.7 percent, report that they drink every day. Our drinkers on average consume two drinks per day. This study also suggests that use of marijuana in a 30 day period occurred for 40.6 percent of the young adults, and cocaine use was admitted by 8.7 percent. Our figures are lower. But the use of heroin is confined to 0.1 percent of the sample of young adults, and other opiates are said to be consumed by 1.0 percent. Our figures for these serious forms of drug abuse are somewhat higher (multiplying the proportion who use a given drug by the proportion of the entire sample admitting to any drug use at all).

In comparing those with homeless experience to those who have not been homeless, there is no significant difference in prison experience. Those who have been homeless are much more likely to have experienced time in jail--nearly twice as likely. However, it is not at all that clear that this represents a "causal" difference. It is just as likely that jail experience is a result rather than a cause of homelessness. That is, jail can occur as a result of public drunkenness, trespassing, or other events that are typical results of homelessness.

There are differences in drinking patterns between those who have been homeless and those who have not been homeless. On two measures, those with a history of homelessness are less heavy consumers; larger proportions do not drink at all, and perhaps because of this, average monthly consumption is lower. Neither difference is statistically significant.

However, those with experience with homelessness on the average have a higher score on the alcoholism scale. About 23 percent of those with homelessness experience score at least one on this four point scale and thus evince at least one symptom; for those who have not been homeless, the proportion is about 14 percent.

There is a large difference in binge drinking. Those with a history of homelessness are over twice as likely to claim to be binge drinkers. Binge drinking is apparently a pattern among about 22 percent of those with some history of homelessness.

One can argue whether patterns of binge drinking or alcoholism are a cause or effect of homelessness. But as we will see, those who are currently homeless have a similar drinking pattern to those who have ever been homeless. While this does not at all solve the causal question, we suspect that a number of binge drinkers and alcoholics tend to use up resources on alcohol and at least temporarily become homeless. Given the low proportions involved, this is clearly only part of the issue; and given the high consumption of alcohol in studies of "the homeless" that were conducted during the 1960s on skid row, the proportion who are alcoholics appears surprisingly small. There appears to be a good number of heavy or problem drinkers among the homeless, but this apparently is at best only a "cause" of homelessness for a small proportion of those who have ever been homeless.

Finally, there is no evidence that homelessness and drug use are associated in any particular manner. According to self-reports, those with homeless experience are equally likely to admit to any drug use at all, and are in fact much less likely to use marijuana. Those with experience with homelessness are somewhat more likely to report use of cocaine or heroin, but the differences are not even close to the level that would indicate statistical significance.

Further Analyses

The role of household arrangements in homelessness would seem to be a rather striking finding in the above tables. While those who have been homeless are somewhat less likely to be married, the most significant findings are that they are rather unlikely to live in a household with other relatives and that they are likely to live in a one-person household. One might wonder whether the differences are at all linked to other factors.

Therefore, cross-tabulations of whether individuals lived in a household with relatives and some of the other characteristics of note were developed. Living with relatives was not related to binge drinking, which is perhaps the best single measure of alcoholism in the sample. Those who had been in a mental hospital (who, Chapter 3 will note, are also more likely to be homeless) were less likely to live with relatives than those who were not, but the difference is not statistically significant (3.7% of this group lived with relatives). Those who had been in out-of-home care as a child also were slightly less likely to live with relatives, but the difference was not statistically significant (3.5% lived with relatives). Those who had served in the military (2.3%, chi-square of 6.39) were less likely to live with relatives. On the other hand, blacks were more likely to live with relatives (9.7%, chi-square of 7.22). Those living with relatives and those who did not had very similar scores on a summary measure of mental health status, the GSI, which will be described in Chapter 3.

Insofar as the measure of living in a one-person household is concerned, this household status is more common among those who have been committed to a mental hospital (71.4%, chi-square of 14.53), those who have been in the military (75.6%, chi-square of 30.8), and those who are binge drinkers (72.2%, chi-square of 16.05). There is no relation between living in a one-person household and having been in out-of-home care as a child. Blacks are less likely to live in a one-person household (48.9%, chi-square of 4.06). The measure of mental health status, mentioned above, has no relation to this variable.

THE CURRENTLY HOMELESS

A comparison of the currently homeless to those who are domiciled at the time of the survey is most appropriate in considering the nature of the most recent events experienced by those who have become homeless, compared to others. It is less appropriate when considering general background; for, among those who are not homeless at present, there are a group of individuals who have had homelessness experience in the past. A comparison of the homeless and the non-homeless on background characteristics is in part a comparison of two sets of individuals with some homelessness experience.

Nevertheless, simple comparisons of the currently homeless to those who are not currently homeless would not be possible if there were gross differences in background. As Table 2.4 suggests, the currently homeless individuals do not differ greatly from those who are not currently homeless on general background traits. The average age of the two groups is similar, although the currently homeless are a bit younger. The two groups have a very similar average number of years of education, and each group has worked a similar proportion of their adult lives, according to self-reports.

There are some minor differences in demographic traits in that the currently homeless are slightly less likely to be black, and more likely to be female. Both differences are statistically significant. We suspect that the first difference occurs because more blacks who obtain free meals also have other supports (e.g., help from relatives).

In the case of the relation of sex to homelessness, one must keep in mind that the vast majority of the currently homeless are male according to these results, even if females are a somewhat greater proportion of the currently homeless than of our other groups. The results simply indicate that among those very poor, and often male, users of free meal programs, females are more likely to be in the homeless group than in the group that makes use of meal services and is not homeless. To repeat an argument, perhaps women who are poor are normally able to avoid the free meal programs because many have custody of children and obtain AFDC. However, once the women reach a crisis, they are less likely to remain domiciled during the crisis--again, perhaps due to the existence of children or other dependents.

This pattern might also explain the results involving household arrangements. While there are small differences, similar, small proportions

Table 2.4

Selected Characteristics of the Currently Homeless and Not Currently Homeless (Number of Respondents)

	Among Total Sample	Among the Currently Homeless	Among the Not Currently Homeless
Demographics and Background			
Average Age	37.6 (527)	36.1 (178)	38.3 (351)
Percent Black	69.2 (527)	62.7 (175)	72.5* (351)
Percent Male	70.2 (532)	63.2 (178)	73.7* (353)
Average years of education	10.9 (529)	11.1 (177)	10.9 (352)
Percent currently married	9.0 (530)	6.2 (177)	10.3 (353)
Household Composition			
Intact family household	7.2	5.9	7.9
Childless couple household	1.9	0.6	2.6
Woman with children, no husband household	15.4	21.5	12.4**
Man with children, no wife household	2.3	2.5	2.2
Household with other relatives	17.6	2.2	25.5**
Single-person household	52.6 (501)	64.2 (171)	46.6** (330)
Other Attributes			
Percent with prison experience	12.6 (523)	11.2 (173)	13.3 (350)
Percent with jail experience	57.1 (521)	53.1 (172)	59.2 (349)

(Continued on next page)

Table 2.4--Continued

	Among Total Sample	Among the Currently Homeless	Among the Not Currently Homeless
Other Attributes			
Percent consuming any alcohol in last 30 days	58.1	48.7	62.8**
	(524)	(174)	(350)
Average standard units consumed in 30 days	65.3	63.9	66.0
	(523)	(174)	(349)
Alcoholism scale score:			
0 to 4	0.40	0.43	0.39
Percent with any symptom	20.2	19.5	20.6
	(524)	(174)	(350)
Percent of sample who go on drinking binges	17.6	18.4	17.2
	(533)	(179)	(354)

Numbers and percents are rounded.

For currently homeless and not currently homeless comparison:

* $p < .05$
** $p < .01$

are likely to be currently married--6.2 percent of the homeless and 10.3 percent of the non-homeless. The proportion of intact families is also similar, at about 5 percent for the homeless and 7 percent for the non-homeless. And while the homeless are slightly less likely to be part of childless couples, the differences are not statistically significant.

One statistically significant difference is that women who head families with children comprise 23 percent of the homeless but 15 percent of the non-homeless members of the sample. Once again, this might reflect the fact that women with children, when they receive AFDC and are not in a crisis, are less likely to be in the sample. In addition, as in the case of the ever homeless-never homeless comparison, the homeless are more likely to be in their own, independent households. The difference is somewhat smaller than in the case of the ever-never homeless comparison; however, this occurs because the proportion of female headed families reduces the number in independent households in the currently homeless category.

Other Attributes

Some of the discrepancies between ever being homeless and currently being homeless affect comparisons on other attributes that have been considered above. For example, there are no differences between the currently homeless and the not currently homeless on drinking behavior according to any of the three measures, nor are there differences in jail experience. However, if one compares the currently homeless to those who have never been homeless (this can be accomplished by across-table comparisons), the former group is slightly more likely to have experienced jail, or to binge-drink. The homeless group also scores more highly on the scale of alcoholism symptoms. No differences exist in terms of the average number of drinks consumed in a month, however. Thus, the currently homeless and the previously homeless are somewhat similar in this regard; those who have never been homeless differ greatly. The direction of cause and effect for the relation involving jail is in doubt; in the other cases, this evidence remains consistent with the perception that alcoholism or problem drinking is a cause of homelessness over and beyond the problem of being very poor. Basically, however, the trait does not seem particularly related to a current spell of homelessness, just to any spell of homelessness; perhaps drinkers periodically move in and out of homelessness.

Housing and Rent Patterns

Table 2.5 compares the currently homeless to those who are not currently homeless on some traits for which the comparison seems most appropriate. One is housing patterns. This issue is important due to evidence that housing costs are becoming an increasingly large component of the income of the poor, and might lead some individuals to become homeless simply because they could not afford housing.

In looking at housing, we compare the nature of the dwelling unit that homeless individuals just left to the nature of the dwelling unit that domiciled individuals use. In addition to information on the nature of housing, this helps to indicate if the homeless had unusual housing circumstances that might be implicated in their movement into homelessness. Our inquiry concerns their last dwelling unit, and thus, what preceded their becoming homeless this time. It cannot consider where the homeless with repeated periods of homelessness resided before they ever become homeless.

Table 2.5

Selected Past and Current Living Arrangements of the Currently Homeless and those Not Currently Homeless (Number of Respondents)

	Among Total Sample	Among the Currently Homeless	Among the Not Currently Homeless
Rent			
Percent share or shared rent	36.0 (510)	31.5 (171)	38.3 (340)
Rent paid or pays:			
Average for the individual per month	$137.71	$168.42	$121.78**
Percent paying or paid no rent	12.6 (485)	13.1 (166)	12.0 (319)
Living Arrangements			
Percent lives or lived with:			
Family	42.3	41.1	43.0
Other relatives	7.7	3.5	9.8*
Friends	15.7	17.1	15.0
Alone	40.2 (501)	44.7 (166)	38.0 (335)
Number lives or lived with	2.19 (505)	2.69 (167)	1.94 (338)

Numbers and percents are rounded.

For currently homeless and not currently homeless comparison:

* $p < .05$
** $p < .01$

As Table 2.5 suggests, only a minority of the sample shared (36%) rent. The average rent the individual paid--that is, taking out what was paid by others--was low, at about $138 per month. While it is not on the table, the median rent was somewhat lower, at $125. However, such rent payments are not low when compared to incomes of this group. For example, typical General Assistance benefits are only $154 per month, which is not much more than a typical rent rate. Clearly, the very poor spend an enormous proportion of their income on rent (see Chapter 5 for income figures).

Many believe that the very poor avoid homelessness because others allow them to live for free. However, this does not appear to be the case. For the entire sample, only 12.4 percent of the respondents claimed that they paid no rent. While it is not reported on the table, the typical individual who paid rent claimed to pay about two-thirds of the entire rent of a dwelling at which he or she resided.

A stereotypical of the skid row homeless was that they lived alone when they had a dwelling unit. It is perhaps surprising that this also is an inaccurate representation of the sample. Only about 40 percent of the sample lived alone, while the remainder lived with other individuals--children, friends, or relatives. In general, 42 percent of the sample lived with immediate family, 8 percent with other relatives, and 16 percent lived with friends. As Table 2.5 notes, even including those who lived alone, the typical individual shared living quarters with 2.19 individuals.

When those who are homeless are compared with those who are not, many similarities emerge. Compared to the non-homeless, the homeless are about equally likely to have shared rent, and have lived with a similar number of people, on average. In their last dwelling unit, 13.1 percent lived for free, compared to 12.0 percent of those who did not become homeless. The homeless shared a dwelling unit on average with similar numbers of individuals. The number was 1.94 for the 338 reporting individuals who are not homeless, and a slightly, but not statistically significantly larger 2.69 for the 167 currently homeless individuals.

There is one telling difference, however. The homeless were likely, to a statistically significant degree, to pay more rent than did those who are not homeless. The difference is roughly $46 a month. Compared to the incomes of the poor, this difference in rent is quite large. General Assistance checks are only $154 a month for an individual; yet the average rent for those who became homeless was $14 more than this, per month. This severe housing-related financial crisis that might have given rise to homelessness.

Living Arrangements. Household arrangements, mentioned previously, are not identical to living arrangements. Accordingly, members of the sample were asked about who they live with, if currently in a residence, or who they lived with in their last residence, if they are now homeless. As the table notes, the currently homeless are equally likely to live alone, with friends, or with members of the immediate family, but less likely to live with other relatives. Some of these results are misleading. This is because the previously homeless members of the sample are the least likely of the three groups (currently homeless, previously homeless, never homeless) to live with immediate family and the most likely to live alone. Three-way comparisons suggest that the never homeless rank highest on residing with immediate family and lowest on living alone, that the previously homeless have the opposite characteristics, but that the currently homeless are in between. Differences are statistically significant. One might guess that the lack of an ability to live with relatives and members of the immediate family might to some degree "cause" homelessness, because individuals can more easily fall into a financial crisis with no back-up when living with friends or alone.

Because the previously homeless also are likely to live alone or with friends, such living arrangements do not seem to preclude exits from homelessness. They are, instead, associated with occasional periods of homelessness when such crises occur. It even is possible that the previously homeless have a greater propensity to live alone or with friends because they had already lost their ties to others when they became homeless, and did not usually gain them again even when finding a place to stay. Because some of the currently homeless lost some ties just before the current spell, reports of their past ties may overrepresent possible alternates to homelessness. Evidence from the previously homeless makes us doubt whether many such individuals will become reunited with family after the period of homelessness ends, however.

The homeless lived with at least as many other people and as often paid and shared rent. Thus, the reason for the relation of living arrangements to homelessness is not likely to reflect the relative amount of rent paid. We could guess that the more important reason or the difference is the efficiency of sharing with relatives as opposed to with friends. Perhaps relatives are more willing to allow individuals to avoid paying their share of the rent when times are bad; perhaps other costs, such as for food, are lower. Indeed, as will be demonstrated in Chapter 6, living arrangements and rent are independent predictors of homelessness in multivariate analysis.

It is a bit difficult to estimate exactly who it is the homeless lived with, when they lived with members of their immediate family. This is the case because the questions were not detailed. However, if one subtracts from those claiming to live with immediate family those who, at the time of the survey, included in their household spouses and children, about 14 percent of the homeless lived with other members of the immediate family, perhaps parents. The contrasting proportion for those who are not currently homeless is about 28 percent--and this includes some of the previously homeless individuals who are not likely to live with family.

Another issue is whether the break-up of living arrangements caused homelessness. One approach to the issue is to compare the proportion living alone before homelessness occurred to the current household arrangement variable. In this case, perhaps the best groups to compare are the currently homeless and the never homeless; the previously homeless may have experienced a change in living situation at a much earlier time, which may not have been reversed--indeed, these individuals are the most likely to live alone in the sample.

Of the currently homeless, 44.7 percent reported living alone in their past dwelling. This is about 20 percent lower than the proportion who claim to be in a one-person household (about 64%). At most, then, 20 percent may have lost a dwelling with others at the time they became homeless. The homeless differ on this trait from the never homeless, of which 23.3 percent claim to live alone in their current dwelling unit, and for which the proportion living alone and reporting a one-person household (27%) is quite close. It thus is likely that living alone before becoming homeless was common, but that in a moderate proportion of the cases, homelessness resulted when a previous household arrangement was disrupted. Another way of carrying out such an analysis is to subtract those who lived with relatives among the homeless from those now with relatives. The difference is about 17 percent.

Some researchers attribute homelessness to family rejection. Few, however, have evidence concerning how explicit rejection has been. While our data can only speak to events that directly preceded the current spell of homelessness, it is interesting that the currently homeless were rejected by relatives other than their spouses or children with only moderate frequency. It is appropriate to conclude that for the majority of those living alone, either living arrangements were disrupted earlier, this group was rejected earlier, or this group never had other relatives with whom it was practical to live.

STATED REASONS FOR HOMELESSNESS

Table 2.6 presents reported reasons for homelessness among the currently homeless. Given this obvious long-term interaction between homelessness and other life events, one must not take self-reports of the causes of homelessness as a perfect representation of all reasons for homelessness. Rather, these attributions are likely to consider the direct preceding condition for the current spell of homelessness, rather than the long term problems that gave rise to it. For example, an individual who lost a job three years ago is not likely to attribute a recent spell of homelessness to this, even if there is an indirect relation.

Table 2.6

Stated Reasons for Homelessness

(n=151)

Reason	Percent Giving Reason	Number Giving Reason
Just moved	39.9	60
Evicted for non-payment	50.1	75
Argument with landlord	21.9	32
Argument with roommates	33.1	49
Building torn down or condemned	12.9	19
Could not pay taxes or utilities	11.8	17
Left or lost job	42.6	63
Still working but making less money	16.2	24
Lost some or all welfare benefits	15.9	23
Other	33.8	51
Of Evictions:		
Court order	14.4	11
Landlord asked	30.7	23
Left on own	32.0	24
Other or didn't know	22.7	17
Of Other:		
General economic	23.5	12
Illness/dependency, etc.	9.8	5
Choice	5.9	3
Fire/release from institution	7.8	4
Family disruption	7.8	4
Other	43.1	22

Note: Numbers and percents are rounded.

The stated reasons for homelessness might be most useful for analyses of ways of intervening in crises. That is, the reasons might demonstrate which events directly preceded homelessness, and thus indicate what interventions might serve to avoid the particular event--if not to avoid long term poverty. Reasons also suggest some more details about the role of housing problems.

Rather than relying on open-ended questions, a series of yes or no responses were sought on a number of possible reasons for homelessness. Some of these involved the specific way housing was lost (e.g., eviction or having an argument). Others involved attributes of the economic crisis.

Table 2.6, which presents some of these responses, suggests that the most common response was that eviction triggered homelessness. However, this was a response of a scant majority of the respondents. Direct loss of housing by eviction was not shared by everyone.

Other related responses add to the total number reporting a direct loss of housing. A considerable 13 percent of the sample claims that homelessness occurred because their building was condemned or torn down. This is evidence for a direct contribution to homelessness by regentrification--and also of the failures of relocation programs. Twelve percent claimed that they left their dwelling because they could not keep up with taxes or other payments. A small number lost dwelling units due to burnouts, and a small number due to release from an institution. As will be detailed in Chapter 3 in other ways, loss of a place to stay due to deinstitutionalization was not a prime cause of homelessness.

On the other hand, a fair number of people listed reasons other than these purely economic ones for losing a dwelling. For many individuals, an argument triggered the event. For example, 23 percent claimed that an argument with a landlord led to homelessness; one-third claim that an argument with someone with whom the dwelling was shared led to homelessness. Open-ended responses included 3.7 percent who give abandonment by a mate as a cause of homelessness, and 1.6 percent who responded that spouse abuse was an important factor.

Less Immediate Causes

The reasons mentioned above focus on the immediate cause for the loss of a dwelling unit. But respondents were also queried about more general issues that might cause homelessness. Their attributions are also reported on Table 2.6.

The table notes that roughly 40 percent deem their homelessness as caused simply by just moving into the area. As will be noted, below, in most cases this does not imply that the individuals voluntarily left a dwelling unit elsewhere and moved to Chicago. Rather, moving into the area seems to be one reason individuals often attribute for generally being unable to adequately take care of themselves.

In addition, roughly 43 percent of the respondents attribute homelessness to losing or leaving a job. This appears to be the primary attribution of long-term causation. A smaller proportion attribute causality to earning less money while still working (roughly 30 percent of the homeless are working, primarily at day labor, as will be discussed in Chapter 5). About 16 percent attribute homelessness to the loss of some or all welfare benefits. Smaller proportions suggest such other reasons as an inability to find a job, drinking or drug abuse, physical health problems, or their own choice. We assume that those individuals who do not report that a change in circumstances led to homelessness often were poor for a long period but experience no sudden economic change that caused homelessness.

Types of Evictions

One might expect that those who say that they were evicted are legally evicted, that is, evicted through a court order. If so, then services delivered at the point of eviction might help to avoid this state. However, such evictions apparently are not common. Of those evicted, only about 14 percent responded affirmatively to a direct question about whether they were evicted through a court order. It was more than twice as common for individuals to just leave, or to simply be told by the landlord to leave. The number of those who do not know what type of eviction they had is about the same as the number who were formally evicted.

Thus, there are a few of the many evicted individuals who might be helped by services at the point of a court order. However, more common are instances in which eviction apparently is informal, or in which individuals simply give up their dwelling units. Any emergency services program for the evicted would require a broader scope than only those who are formally evicted.

Further Analysis

There is good reason to believe that many respondents might give multiple answers. An individual might have been evicted, for example, but might also have had an argument with a landlord, perhaps over the eviction. Therefore, a more accurate portrayal of the reasons for homelessness may be one that makes the causes mutually exclusive. Table 2.7 reports results concerning certain, selected, self-reported reasons in this way; it reports the proportion of the sample whose dwelling was lost (torn down, burned out, and so forth), the proportion who did not experience this but were evicted or could not pay bills; the proportion experiencing neither of the two but imputing homelessness to arguments or to problems with a roommate; and the proportion experiencing none of the three but imputing homelessness to recent arrival in the area.

Table 2.7

Reasons for Homelessness (Mutually Exclusive)
(n=137)

Place Torn Down Burned Down, or Condemned	Eviction/ Can't Pay Other Bills	Arguments/ Abuse, Etc.	Just Moved
16.8% (23)	50.5% (69)	21.3% (29)	11.4% (16)

Note: Fourteen out of 151 potential respondents listed no such reason. Numbers and percents are rounded.

In this instance, clearly the chief reason is eviction. This reason is given by half of the respondents. However, a surprisingly high 17 percent report that their dwelling unit was lost. This suggests that, for a sizeable group, once housing is lost by accident, individuals have a problem in reclaiming a housing unit. Indeed, putting the two statistics together, about two-thirds of those reporting suggest a direct economic cause for homelessness--eviction--or the loss of a dwelling unit and perhaps an inability to find another at an affordable price.

In contrast, roughly 23 percent claim that an argument (with a landlord, spouse, or with a roommate) caused homelessness. This somewhat small proportion of non-economic loss, in fact, is consistent with our analysis of household and living arrangement data, in which the loss of a tie to someone other than a spouse seemed likely in about 17 percent of the homelessness spells. Finally, 11 percent impute causality to just moving into the area, and not to any of the above reasons. It is important to note that even among this 11 percent and the 23 percent who consider an argument as the major cause, it is possible that economic difficulties are involved in an indirect way.

Further Cross-Tabulations

Do specific types of individuals become homeless for different reasons? To briefly assess this, the above four-way categorization of reasons was cross-tabulated by a small number of other variables. There is a relation between the four categories and being a single parent (chi-square is 13.56). The most striking patterns among this population is that 44 percent of single-headed families say they were homeless due to arguments, but only 4 percent say that they were homeless due to recently moving into Chicago. That is, nearly half of this group had apparently been forced out of a dwelling unit for reasons other than eviction.

Surprisingly, binge drinkers, those who had been in the military, those who were not receiving welfare, and those who had been in a mental hospital demonstrate no unique pattern. This is a first clue to a pattern that will be found, repeatedly. In particular, those who might be more "alienated" or "pathological" are not so unique in patterns of homelessness and do not have particular problems of mobility or of getting into arguments. Blacks did differ from all others on patterns of homelessness (chi-square is 18.11). The major differences are the tendency of blacks to be more of those homeless due to an argument (26.6 percent had this reason compared to 9.0 percent of others), but to fail to list recently moving into the area as a cause of not having a home (only 3.3 percent give this reason). The fact that more blacks live with relatives might be implicated.

The Search for Housing

Individuals who had ever been homeless were also asked a series of questions about their search for housing at the time when homelessness was threatened. These questions were designed to determine whether there was something about their search behavior that could give us more information about problems with the housing market or with related individual behaviors that could give rise to homelessness. Table 2.8 summarizes some of the more important results.

One of the basic issues is that the homeless had very little time in which to find a place to stay. While one individual claimed to have about two years notice, and the inclusion of this individual greatly affects the mean, it should be noted that about half of the reporting individuals claim to have had six days of notice or less, while two-thirds had two weeks notice, or less. Twenty-one percent had no notice, at all. This of course is consistent with the lack of court ordered evictions among those who lost their housing due to evictions.

Table 2.8

Selected Housing Search Behavior of the Ever Homeless

Behavior	Response	Number of Respondents
Average days of warning of housing loss	18.9	302
Median days	6 days	302
Percent not looking for a new dwelling	32.0%	328
(Of the above) Reasons for not looking (percent):		
No money to pay	73.0%	107
Not able to look	37.2%	105
Had a temporary place	34.1%	105
Did not think a place was available	26.0%	104
Did not want a place	16.6%	105
Waiting for a specific opening	10.5	105
Percent looking for a new dwelling	68.0%	328
(Of the above) Methods for searching (percent):		
Ask friends or relatives	82.7%	226
Search neighborhood	70.1%	226
Search newspaper	53.9%	226
Go to a social service agency	23.8%	226
Go to a real estate agent	17.1%	225
Other	14.9%	224
Percent finding no place	21.5%	212
Average number of openings found	3.0	212
Median number of openings	2	212
Selected reasons for not accepting an opening (percent):		
Too expensive	70.5%	155
Security deposit too high	26.4%	155
(Stated) Other	26.4%	151
Was turned down	18.6%	154
In bad neighborhood	16.5%	155
Too run down	17.2%	155

Numbers and percents are rounded.

Of those who responded to the question, 32 percent say that they did not look for another place to stay at all. In response to closed-ended questions, the reasons why these individuals did not search become apparent. Seventy-three percent of these respondents said that they had no money for a place to stay; 37 percent said that they could not look for a place to stay. The only other particularly common response, mentioned by 34 percent of those who did not search, was that the individual had a temporary place to stay--perhaps the house of a friend or relative. There is not much evidence that large numbers refused housing or did not want it.

For those who had looked, the vast majority claim to have asked friends and relatives, and over two-thirds also simply walked around the neighborhood looking for housing. About half of the sample claims to have looked in the newspaper. Notably, few individuals went to a social agency or to a real estate agency.

Roughly 22 percent of those who searched for housing found no openings at all. The majority found from one to three openings; the average is about three. Tellingly, when asked in an open ended manner why the individuals did not take the opening, 70 percent of the respondents who found an opening gave the lack of sufficient funds as a response. Only two other responses were given by at least one-fourth of the respondents: that the security deposit was too high, or an "other" reason. Note that somewhere below 20 percent said that the unit was too run down. Very few seem to have rejected the unit for any other reason. Nearly 20 percent of the respondents say they were turned down, however.

We originally wished to compare this search behavior to that of those who were recently evicted but avoided homelessness. Of those without significant homeless experience, however, only 18 individuals, or 8.4 percent of the other respondents, claimed to have been evicted in the last six months. Basically, nearly anyone in our sample who was recently faced with eviction or loss of a dwelling unit did lose that unit and became homeless.

One basic finding of this section thus must be that the vast majority of those who lost a home had very little time to find another. This might often be moot, however, since a moderate number of individuals did not look for a place to stay largely due to the lack of any cash. For others, it was common to state that the lack of funds for rent or perhaps for a security deposit lead to a failure of the search. We do not know if there were other low cost dwellings that individuals did not find, but as far as the data go, evidence simply suggests that most of the homeless could not afford any housing units they came across.

SUMMARY

The picture of homelessness that can be derived from the survey and statistics involves two separate sets of issues. One is that the homeless are a sub-set of the very poor. Like many individuals in crisis, the homeless have a history of sporadic work and below average income. Most are male, although some significant proportion are women, particularly women with children. Such individuals do not perceive themselves as coming from remarkably poor families, but have at best had working class level jobs at the height of their short careers. As one might expect, given the demographics of poverty in general, the sample of the very poor in general and the homeless in particular are both heavily black. Roughly half of the sample is between 25 and 40 years old.

Because of these similarities, we suspect that in cities, as poverty increased over the last decade, the potential for homelessness also increased. That is, those who are very poor have a finite probability of becoming homeless, and more such individuals were in this state, over time.

Evidence concerning rents suggest that homelessness is at times an extension of poverty. Rents are rising. Many of the very poor pay a high proportion of their income for rent--a proportion that will be easier to calculate after the nature of incomes is presented in Chapter 5. The homeless paid even more than average, so that homelessness might, in part, simply result from a random event, an inability to find a dwelling at a reasonable cost. This is consistent with the fact that only a small number attribute their own homelessness to an argument with those with whom they lived. Evictions or loss of the dwelling unit dominate their own beliefs about why homelessness occurred; many could find some opening for housing but could not afford the housing unit.

But there are particular traits that seem to increase the probability of homelessness. For example, living alone, without relatives, or being a single parent apparently contributes to homelessness, and these traits also increased over recent years. Thus, among the very poor, those with a history or a current spell of homelessness seem to have particular life situations that might make for a more difficult economic situation; that is those with experience of homelessness seem to be more isolated from others, and perhaps less likely to have financial (or emotional) supports in time of crisis.

Homelessness appears to be a repeated event in the life of many. Perhaps for this reason, the currently homeless individuals often do not look as different from the comparison group members--who include many individuals who have been homeless at one time--as one might expect. Nevertheless, there is evidence that those who have at any point in time been homeless are more likely to be heavy consumers of alcohol. This does not seem to be the cause of homelessness for many, but it seems to play a particular role in the homeless experience of a minority.

Finally, many individuals who have experienced homelessness appear to have rather unusual histories of institutional experience, in terms of jail, military experience, or out-of-home care as a child. The former can as easily be a result, rather than a cause of homelessness. In any case, the entire sample has had a surprisingly high level of jail experience. We will later argue and have already hinted that some of the reasons for the high levels of institutionalization in other ways appear to include an interaction of economics with personal situations. That is, those with such histories are more likely to live alone or without relatives when they are not married; this lack of ties appears to make crises turn into homelessness more frequently.

One specific finding from the analysis of stated reasons for homelessness is that large numbers lost a dwelling unit through what might be called an informal process. Apparently, many of the evictions occurred without a court order. And even though there are meant to be housing services that help those whose buildings are torn down, a number became homeless by this route. Perhaps all too many individuals leave their housing units before services might be offered, or are informally convinced to leave by landlords.

Chapter 3

The Mental Health System

INTRODUCTION

The prevalence of mental illness among the homeless has been an issue of great disagreement. For example, Arce and Vergare conclude that 20-50 percent of all homeless persons have serious and chronic mental illnesses (Arce and Vergare, 1984) while the Department of Health and Human Services reports that acute or chronic illness is a principle characteristic of 33-66 percent of the homeless in shelters (DHHS study, 1984, quoted in Levine and Stockdill, 1986). There are many methodological reasons for such inconsistencies. Studies have used diverse measures and definitions of mental illness, as well as samples from very different, and sometimes biased populations (compare for example, Vergare and Arce, 1986; Fischer _et_ _al_., 1984; Lipton, Sabatini, and Micheels, 1986). Indeed, as samples have improved, there has been a reduction in the common estimated prevalence of mental illness among the homeless (Katz, 1986). However, homelessness is still seen by some as largely a mental health problem.

The emphasis on mental health and homelessness tends to be placed on the chronically mentally ill--those with life-long, serious, mental health problems (APA Task Force Report on the Homeless Mentally Ill, 1984; and Bassuk _et_ _al_., 1986). In particular, emphasis is often placed on schizophrenics (Kaufmann, 1984). These individuals seem to be the least able to take care of themselves, and thus, the most vulnerable (Frazier, 1985). They are said to make up a sizeable proportion of the homeless.

Very few argue that the problem for schizophrenics and other chronically mentally ill persons is the failure of institutions to cure them: cure is rather infrequent. The issue is often said to be maintenance. For example, the chronically mentally ill may require special placements, drug treatment, or counseling for their entire lives. Systematic failures to provide for their needs may make homelessness quite likely. Nonetheless, there are a rather large number of distinct arguments concerning the exact mechanisms by which mental health problems result in homelessness.

Mental Hospital Release

There is some concern that the homeless represent those who have been released from mental hospitals. Over the course of the 1970s, public policy favored the deinstitutionalization of the mentally ill. The result of this direction was a dramatic decrease in the census of mental hospitals. Between 1955 and 1974, the resident census of public mental hospitals declined from 559,000 to less than 130,000 (Frazier, 1985). In 1955, 73 percent of all patient care episodes occurred in hospitals; by 1980, that figure was reduced to 27 percent (Levine, 1984).

Critics of the deinstitutionalization movement point to the fact that cuts in funding and community attitudes toward mentally ill persons prevented a comprehensive supportive service system from developing. Some argue that persons leaving institutions were frequently left to fend for themselves within a large bureaucratic service system and hostile community (Williams, Bellis, and Wellington, 1978; Bassuk and Gerson, 1978; Bassuk and Lamb, 1986). Lacking the support that they needed to maintain a job, ties to family, welfare benefits and so on, many of those released may have become homeless either due to a lack of income, inability to secure work or welfare, or an inability to independently handle such day-to-day problems as paying rent or living with others. Reports of instances in which mentally ill individuals were simply bussed to a central city and released on the street to become homeless raised the possibility that individuals were actually pushed out of institutions without any attempt to plan for their needs in the community.

Others argue that the homeless mentally ill may have been sent to treatment programs in the community or to family members upon discharge, but these referrals were often inappropriate or poorly planned. When the referrals broke down, homelessness was the result (Goldfinger and Chafetz, 1984).

Lack of Admission

A second series of arguments assert that it is not the failure to plan for those who have been hospitalized but the initial lack of admission which is the critical factor in homelessness. Proponents point out that only a minority of the homeless have ever been in a mental hospital (Lipton, Sabatini, and Micheels, 1986; Drake and Adler, 1984). Indeed, certain mentally ill groups, particularly young chronics, have never been hospitalized (Frazier, 1985 and Bachrach, 1984). Further, the real growth in the number of homeless apparently occurred many years after hospitals reduced their inpatient populations.

To the extent that hospitalization is discouraged as a result of the deinstitutionalization movement, however, the movement may indirectly relate to homelessness. It may be more difficult for those who need hospitalization to get treatment. Without it, some may eventually be unable to garner and make use of resources needed to avoid homelessness. Further, community services may be tied to institutions so that those who have never been hospitalized may have limited access to necessary care. In support of this argument, some claim that the homeless mentally ill may have borderline personalities and are not ill enough to be institutionalized. They may not be well enough to survive on their own, however.

Another related view is that the mentally ill individuals on the street are those who are the least likely to be served by agencies that might help them avoid homelessness. Many might be young paranoids who simply will not apply for SSI or allow existing mental health agencies to serve them. Or, they may be the minority who drop out of services, stop taking medications, and refuse additional aid (Lamb, 1984; Drake and Adler, 1984). Several additional contributing factors include a decrease in the housing stock formerly occupied by many mentally ill people (Frazier, 1985; Levine and Stockdill, 1986), the stigma of mental illness, and its impact on the ability of the mentally ill to find employment and housing; and the reluctance of the mentally ill to seek help or their preference for life on the street (The APA Task Force Report on the Mentally Ill Homeless, 1984).

This chapter investigates the relationship between mental illness and homelessness in Chicago. It is divided into two parts. The first section focuses on the current system of mental health services in Illinois and the Chicago area in particular. The second analyzes the mental health data from the survey.

ILLINOIS' MENTAL HEALTH SYSTEM

Overview

The service system in Illinois is coordinated, and often also funded and administered by the Department of Mental Health and Developmental Disabilities (DMH/DD). The agency's budget is about $600 million per year. Two thirds of this budget continues to fund the institutions for the mentally ill or developmentally disabled. The institutions include 21 state hospitals for acute, intermediate, or extended care. In the Chicago area, there are four facilities which provide acute psychiatric care. Of these four, Chicago-Read is the largest; in total, there are about 8,500 admissions per year at these four facilities but admissions to Read alone account for 6,000.

Of the remaining 200 million dollars in the DMH/DD budget, $95 million is used to serve the mentally ill in the community. In addition, roughly $11 million in federal funds is added to the state money for community programs. The remaining funds support community residential placements.

There are 52 planning areas in Chicago and each planning area has some type of community mental health program. In Chicago, the city contributes about 5 million dollars and, along with $4.5 million in state funds, runs 19 city mental health clinics in addition to community mental health centers as part of its general community services effort. Fourteen of the clinics are fully funded by the Department of Mental Health and these are the only ones which provide aftercare services.

Funded community programs, of which there are 180 state wide, include community mental health centers, once heavily funded by the federal government, as well as specialized programs. These specialized programs include day programs such as partial hospitalization, psychosocial rehabilitation, and day activity centers with vocational treatment. Outpatient treatment is also available and encompasses both crisis intervention and psychological treatment.

Historical Perspective

The Illinois mental health system is quite similar to that of the nation in that it has largely reduced its institutional capacity. Illinois is in fact often placed among those states singled out as initiating community based programs (Taber, 1977). Both the Zone Program of 1960, and 708 Act authorizing the creation of local Mental Health Boards with the power to tax for community mental health and mental retardation programs, were enacted before federal funding of community mental health centers was initiated (Taber, 1977). But, practical considerations interacted with ideologies about community care and treatment to promote change. Illinois' "... mental institutions in the early 1960s were so crowded and understaffed, that almost any alternative place for care and treatment would have been preferable" (Ragan, 1974, p. 12). Thus, between 1959 and 1983, there was an 82.3 percent reduction in the state institutional resident population from 49,000 to 8,674 (Wallen, 1984).

As the use of mental health institutions decreased, attempts were made to increase the use of community-based facilities. Between fiscal year 1960 and fiscal year 1983, as the state institutional population declined, unduplicated active outpatient cases in state funded programs increased by 2,800 percent (Wallen, 1984).

In one sense, community based care began with the development of Community Mental Health Centers. Initially funded through the federal government with the state later adding money, these centers were to serve the mentally ill. However, while the centers created by the act were hailed as the "eventual replacements of the state hospital system, paradoxically [they] were not required to develop treatment programs for the chronically mentally ill" (Williams, Bellis and Wellington, 1980, p. 62). Community mental health centers could serve the deinstitutionalized population, but they also had the option of serving other groups. And the national evidence indicates that it was these "other" groups that they served in the early years (Richman, 1981).

Although it has never been a state which took full advantage of the available funds, Illinois made some progress in providing programs for deinstitutionalized persons as it assumed the federal government's responsibility for funding the community mental health centers during the 1970s. Beginning in the late 1970s, services came to be targeted for specific populations at specific community mental health centers. Some services to the chronically mentally ill were mandated. Community mental health facilities also had to serve, as a certain proportion of their caseloads, individuals who had been institutionalized. Some centers formed emergency teams and began case management programs.

Although the majority of funds were used to support federal programs already in existence, a small percentage were also used to fund new services in the community. Thus, state contracting for community services in general increased gradually during the late 1970s and early 1980s. A number of specific services were targeted through funds passed on to local areas, just as in the case of the Department of Public Aid. Some of these funds were intended to support services that might go to the chronically mentally ill.

Admission Policies

Another impact of the deinstitutionalization movement (nationally as well as in Illinois) was a change in philosophy regarding admissions to institutions. Rather than admit an individual for a long period of time, it was hoped that the period of admission would be short. A "revolving door" approach arose as repeated visits became more acceptable than longer stays. In Illinois, readmissions made up 59 percent of all admissions in 1970 while in 1983, they accounted for 71 percent (Wallen, 1984). The length of time in care also decreased. According to one state official, in 1971, the average length of stay had been 39 days. By 1985, it had dropped to 28 days.

In 1977, admission standards were officially altered to match those implied in federal court cases elsewhere. According to the new Mental Health Code, mental illness alone is not grounds for involuntary admission. Rather, a person also has to represent a danger either to him or herself or to others. An inability to care for oneself and the unavailability of a less restrictive placement are also grounds for involuntary commitment (Mental Health and Developmental Disabilities Code, 1979, Article 6, Sect. 3.600-611; Article 7, Sect. 3.700-706).

To insure that the standards for admission were met, the state developed formal "deflection" programs which screen individuals before they even got to the door of the state hospital, thus preventing institutionalization. Such programs are carried out by a range of community agencies including community mental health facilities and hospitals with psychiatric wards. In some instances, deflection units are attached to programs that are reimbursed for short-term emergency care of up to 21 days which helps to avoid hospitalization.

Discharge Planning

Just as deflection policies are intended to insure that those who are institutionalized are really in need of such treatment, the discharge planning, linkage and aftercare programs are, theoretically, intended to reduce the likelihood of readmission and establish a treatment plan in the community. According to the Mental Health Code, staff must set initial criteria for discharging a patient within 72 hours of admission (Mental Health and Developmental Disabilities Code, 1979, Article 9, Sect. 3.900-903). Each Department of Mental Health and Developmental Disabilities region is required by law to "...set up a plan for discharging patients from state hospitals and referring them to community mental health agencies for additional care or treatment" (League of Women Voters, 1986, p. 10). Care and treatment must be provided in the least restrictive environment (League of Women Voters, 1986). Further, each individual discharge plan must be approved by the patient, the state facility, and community agency (League of Women Voters, 1986). A specific residence to which the patient can go after discharge must be identified in the plan. This cannot be a shelter for the homeless. Those who are discharged to community care as defined by the department must be visited once per week during the first month for a one year period following discharge and once per month subsequent to that time.

Community Residential Care

Strictly speaking, discharges to community placement include only discharges to licensed facilities such as intermediate care facilities (ICFs), skilled nursing facilities (SNFs) or shelter care. (Shelter care in this case is distinct from shelters for the homeless; it entails a supervised living environment for developmentally disabled and mentally ill individuals.) Discharges to independent living, on the other hand, include persons who are discharged to community residential programs as well as to independent settings such as single room occupancy (SRO) hotels, and room and board arrangements.

Information on the national level indicates that in the early years of the deinstitutionalization movement, a large proportion of formerly institutionalized mentally ill and developmentally disabled persons were released primarily to licensed facilities (Wallen, 1984). This was also the case in Illinois; a 1979 Chicago study revealed that 50 percent of the patients in nursing homes were under age 65 (Wallen, 1984). One impetus for the use of nursing homes for aftercare was the availability of Medicaid funds. Beginning in 1971, the federal government allowed states to use Medicaid money for long-term care of mental disease in noninstitutional settings. Illinois interpreted this as meaning that nursing homes could qualify as noninstitutional settings and that the long-term care of the mentally ill within them could be funded through Medicaid. (This was subsequently challenged by the federal government in the early 1980s).

By 1979, the department had begun to look at supporting alternative residential programs beyond nursing homes. A new funding mechanism, whereby funds were given to implement specific initiatives, was first utilized. When new money was appropriated by the legislature for community programs in 1982, this mechanism was used to target services explicitly for care of the chronically mentally ill. Funds were provided for a specified array of services, including residential programs. In 1984, the Community Initiative program for the mentally ill was begun through a special appropriation to the DMH/DD budget;

by 1985, the funds for this program were expected to support 1,201 community residential beds statewide apart from those available in nursing homes or shelter care. In 1982, there were only 392 beds of this type (Wallen, 1984).

The Present Service System

Program Examples. **Model Programs:** Many experts believe that homelessness is best avoided by programs like the Bridge. An "ideal" program and a unique one, it is able to serve only a few of the many who might benefit.

The Bridge is an intensive community treatment program which works with extreme psychiatric recidivists. It is operated by Thresholds, a program devoted to day treatment, residential services, and psychological rehabilitation for those with 3 to 7 prior hospitalizations. The average Bridge client has had about 20 past admissions to a mental hospital; the minimum criteria for program eligibility is five, three in the last year.

The Bridge, which is in theory one quarter of the Thresholds program, speaks to issues more closely related to the homeless. Just a few of their members, as they call those using the program, have been homeless. But according to staff with whom we spoke, others might be homeless if not for the services provided by the program.

The program operates on a model similar to PACT, a famous treatment program in Wisconsin, although it has made some changes. Like PACT, the emphasis is on maintenance, not cure. But unlike PACT, workers always go to the clients and have no programs or group sessions of their own. All the staff are social workers although not all have Master's degrees. Staff see themselves as the glue that holds the system together, helping people negotiate with landlords, with the community mental health center (CMHC), with the welfare department, and with medical personnel. This is about a quarter of what staff do. Dealing with the bureaucracy was in fact identified by our informant as a particularly difficult problem. In order to avoid eviction and homelessness, Bridge staff try to help clients find suitable housing situations, manage finances, and deal with friends or landlords.

The purpose of this advocacy is not cure or rehabilitation. Rather, it is intended to keep individuals out of the hospital (or to help them use the hospital whenever necessary). Staff assume these individuals need lifelong services to stay out of institutions. A few individuals might try to rehabilitate themselves and the Bridge will help, but vocational issues are not the priority.

The Bridge uses staff teams of about 4 or 5 people. No individual is assigned completely to any team member. A team serves 40 to 50 persons, rotating members among the caseload. According to staff with whom we spoke, the team is the solution to staff burnout, covering for vacation time and unstable member-professional relations. Team work also helps when transference or countertransference occurs. New team members without much training learn by joining a team and being socialized into it.

The clients served by the agency are generally chronically mentally ill schizophrenics. A minority have personality disorders or are manic depressives. A few have been hospitalized so much that no category really fits. Staff screen referrals closely, taking those who they believe are the most disabled. Once a case is accepted, it is almost never closed.

Like the Bridge, Sojourners is a "model" program. It is part of the Counseling Center of Lakeview (formerly the Lakeview Mental Health Council), a community mental health center, and is a short-term case management program which was originally started as a deflection program. Due to the demand for housing, the program eventually evolved into a program specifically for the homeless mentally ill.

Sojourners covers the entire north side of Chicago. Referrals come only from Read and include either people presenting for admittance who are deflected or people released from inpatient units who have nowhere to go. According to our informant, staff at Read were initially reluctant to refer people to the program as they believed it would not work. However, the program has served a total of 600 clients since it started in December of 1982. At any point in time, staff, which include a supervisor and six case managers, serve 35 clients. Over a month, 45 to 50 individuals are assisted.

Turnover is rapid. The average time for an individual to be on a caseload is one month and staff intervention is intensive. First, staff try to find housing that is within the individual's budget. They then arrange for a variety of services including emergency food, clothing and financial assistance. They will refer and accompany clients to the community mental health center, pay for medications until a prescription from the mental health center can be obtained, take people shopping and teach individuals how to live independently. If someone cannot handle independent living, staff move them. The status of each case is evaluated almost constantly.

Ideally, program staff try to place people in their "home" community, where they have lived the longest or feel the most comfortable. In reality, however, our informant reported that people had to go to where there was cheap housing. Pockets of cheap housing are in fact often used.

Clients do not come to the agency's office for service. They have the agency phone number so that they can call at any time but, according to the staff we spoke with, the program is not designed for people to come in for help. The staff's philosophy is that problems are out in the community and that is where they should be solved. Informants also felt that it was more of a learning experience for the client if the worker went out and negotiated with the landlord, for instance, when the client was present.

The program will handle a case for longer than a month if there are difficulties with an individual's funding. In other instances, an individual may come out of Read, staff may get in touch with his family, they may agree to help, and the client can be put on a Greyhound bus for home within a day.

Community Mental Health Centers: In contrast to these model programs which may serve relatively few of all chronic clients, many chronically ill individuals have contact with community mental health centers. To better understand the role of community mental health centers in meeting the needs of those who are or could become homeless, we have taken a closer look at five of them.

Two of the centers were originally federally funded as community mental health centers and now receive state funds for mental health services. The other three were city clinics and receive both state and city monies. All are public agencies and all are nonprofits.

All the centers received referrals from the state institutions. In addition, depending upon where the center was located, referrals came from private hospitals, shelters or ICF operators. However, agencies varied in the proportion of chronic persons who were served. Some, particularly those located in areas known to attract many former patients and chronically ill, primarily served this population. Others served a smaller proportion, but chronic persons comprised the majority of persons served at all centers.

The centers had a variety of services ranging from individual counseling for children and adults, to precare services for persons who might otherwise need hospitalization, to aftercare for those who had been institutionalized. Several had emergency or crisis care. Day treatment and alcoholism programs were common as was a case management component whether the agency was "officially" funded to provide case management services or not. Some centers also ran supported living programs for former patients. Most provided concrete cash assistance and had staff who could serve as representative payees. Centers varied to the extent that they emphasized psychotherapy over services designed to meet material needs or assistance with day-to-day problems. For clients who cannot negotiate the bureaucracy of the service system or those unable to handle problems with landlords or roommates, assistance with concrete problems and material needs may be more critical to preventing homelessness than psychotherapy. While all the centers did not have as intensive support services as others, they did recognize that psychotherapy alone was not enough for some of their clients and they were moving away from the provision of therapy alone.

For example, aftercare services to former patients generally included assistance with concrete needs and linkage to necessary services as well as a counseling component. In some cases, agencies ran groups to enhance community living skills. Aftercare clients often participated in other agency programs such as day treatment as well.

Case management was typically a part of aftercare although in some agencies, it was a distinct program in its own right. Generally, case management services were aimed at extreme recidivists in accord with DMH/DD policy. Some agencies clearly specified, in agreement with DMH/DD criteria, that persons in their case management programs had to have had three hospitalizations in one year. This emphasis on the extreme recidivist might have meant that some, especially those with more hospitalizations, avoided homelessness. However, others, who had not been hospitalized as frequently but who might also have benefitted from case management, might not have received the help they needed to remain domiciled. A further limitation to serving a greater proportion of persons in need was that caseloads within those agencies about which we had this information, were generally not very large when case management services were more intensive.

There were primarily two types of case management programs among the centers: less intensive programs with larger caseloads and programs which were more comprehensive. Often, the latter programs included linkage to housing and more in-depth staff intervention. Agencies might have one or both program types and generally, they all had less intensive programs. Those with more in-depth services were usually located in areas where more chronically ill congregated. For example, one mental health center located in a community known to attract many chronics had two case management programs which varied in size and target populations. The caseloads for one, the CLASP program, were small. There were seven workers in this program each of whom was responsible for 10 clients. It was intended to serve those who needed more than the typical one hour per week contact--perhaps four contacts per week--to manage. Without this sort of help, staff felt that a new episode of mental illness or homelessness might follow. Caseloads for the second program, CAP, were much larger. Services were less intensive as well. Both programs formally worked on the DMH/DD criteria of 3 hospitalizations in the last year and 5 altogether.

Two centers had emergency services of some kind. In one instance, this consisted of staff who served as a crisis intervention unit. In the second, the agency had an emergency shelter where individuals could stay for up to ten days if they were in an acute state but not violent. This worked in tandem with an emergency deflection program run by the agency.

Staff of one center, which did not have emergency services, noted that this was an important unmet service need. Similarly, informants from the agency which had the crisis intervention unit stated that they would like to increase the unit's hours to provide more comprehensive emergency coverage.

Intervention strategies aimed at either assisting someone who was already homeless or preventing homelessness from occurring in a case where it was imminent generally took two tacks: 1) assistance to address concrete problems including lack of money and housing; and 2) counseling aimed at ameliorating problems in relationships that might lead to homelessness. Usually, these services were provided to clients who were part of an agency's case management programs. However some, depending upon their view of the causative factors, stressed one approach more than the other. Those who saw homelessness as resulting primarily from the client's psychological disposition and preference for homelessness emphasized counseling more than those who viewed homelessness as resulting primarily from a lack of needed resources.

As noted, some agencies were able to provide cash assistance directly, which could be used to obtain emergency housing. In certain agencies, the funds were great enough to serve as security deposits. In other instances, staff helped people locate housing. Two programs ran their own emergency shelters. Others referred people to housing programs. In still other instances, a center's staff might actively participate in helping an individual find a living situation or negotiate with landlords on behalf of the client. One program, for example, had a housing liaison who located room and board facilities and landlords. She set up agreements with landlords and clients and monitored each situation once housing was in place. Another center did not have a formal system of this nature but staff often knew sympathetic landlords to whom they could refer people and occasionally, they were able to accompany clients in their search for housing. A center's ability to engage in these activities depended to some extent on the number of staff and funds available. For example, agencies who had fewer case managers were less able to spend time actively helping clients look for housing. Other centers did not have any money available for emergency aid.

Several of the agencies served as representative payees for some of their clients. One agency, acting in this capacity, often made loans and negotiated with landlords to forestall eviction until a check arrived. This agency also reported that serving as the representative payee gave staff some control over those who might use their money for things other than housing. Staff could thus prevent homelessness from occurring. Another agency however informed us that it would not serve in this capacity. Client conflicts with family or friends were often related to money and the agency did not want to get involved.

All of the agencies helped those in their case management programs to obtain financial benefits. Some, again, depending on staff availability, were more involved in this process than others. Thus, in one case, staff would walk the client through the process. In another, agency involvement was generally limited to referral only.

In terms of intervening in interpersonal problems that might lead to homelessness, informants reported that their staff spent at least some time negotiating with landlords to prevent evictions when the problem was behavioral. Preventive activity also included intervening with family to prevent or ameliorate conflicts. Additionally, one informant reported that staff tried to develop other support networks so that if conflict occurred, people would have alternative individuals to whom they could turn for help. According to this individual, people often fell into problematic situations because their personal support systems were limited. Again, the level of intervention varied according to the number of staff available to handle these kinds of problems and the center's emphasis on providing counseling versus assistance with concrete needs.

Informants from one agency felt that their center's drop-in center was a particularly helpful program component as it allowed individuals to stay somewhere without requiring treatment and enabled workers to make contacts with persons who might need help.

In sum, some of the services which were available were seen by informants as important to preventing homelessness. However, these were limited by an emphasis on psychotherapy in some centers as opposed to case management and assistance with day to day tasks. A philosophy stressing therapy also constrained the funds available for emergency needs or attention to securing housing. All centers recognized the need for more activity in these areas. Staff had begun to direct their energies to negotiating with landlords, securing emergency housing, and providing case management focused on material needs and practical problems but the numbers served, particularly in the more intensive programs, remained small. Further, criteria relating to the number of hospitalizations may have limited access for some.

Current Admission and Deflection Policies. Those parts of the mental health code concerning the interpretation of "danger to oneself or to others" and the "complete inability to care for oneself in the community" constitute the key portions of the code about which there is controversy. The criteria imply that being mentally ill is not enough to lead to hospitalization; nor is an individual's self-destructive behavior in the form of drinking, refusing to take medications or being out in the cold during the winter without a coat. The sole purpose of the hospital according to the way the code is interpreted, is to act in acute crises where suicide, harm to others, or a similarly critical situation is imminent.

In terms of homelessness, the issue of importance is whether this interpretation prevents people who may need hospitalization from being admitted and whether this failure to admit subsequently leads to homelessness. Further, the extent to which deflection increases homelessness depends upon who is turned away and whether it is 1) those threatened with homelessness; 2) those homeless who could use the mental hospital to escape their situation; or 3) persons who are only seeking a "shelter."

According to one informant, DMH/DD policy is to keep admissions down. The criteria from the Mental Health Code, in theory, relate to involuntary commitments but these same criteria are reportedly used for voluntary admissions as well. Since less than 3 percent of all admissions are involuntary (Lewis et al., 1987), it is possible that more individuals who need care could be admitted without a change in law if state policy differed.

At Read, the facility upon which most of our information is based, referrals may be made directly to the facility but deflection centers may be used first. Deflection rates vary depending on community screening arrangements and local programs. Generally the rate is about 10-15 percent (League of Women Voters, 1986).

Fewer than 20 percent of those who seek admission to Read are turned away. This actually represents a decrease from a 30 percent deflection rate over the last ten years. Although this may have occurred because of increased familiarity with the facility and fewer inappropriate referrals, one official believed that it also had to do with the general climate of services and financial problems. Even though clinical problems are the most important criteria for admission, there appears to be some pressure to admit those who seem desperate, depressed and without another place to go; with an increase in homelessness, financial problems, and the lack of services in general, intake workers believe that such persons are coming to be a more and more serious problem. In FY 1986, 87 percent of the homeless individuals referred to Read were admitted (674 persons). However, the facility could often do little more than take in the most desperate and perhaps establish a placement for them upon discharge.

The use of the hospital as a resource was also noted in a recently released study of state hospital utilization in Chicago. The authors concluded that a significant portion of their sample of mental patients (18%) considered their housing problem a major, if not the major reason for their hospitalization. Further, the authors note:

> The homeless mentally ill return to the hospital more frequently than those patients with more stable housing because they see the hospital as a resource in their lives. For some of these homeless people, "mental illness" itself is an entitlement; it entitles them to a place to stay (Lewis et al., 1987, p. 80).

In some cases, facilities try to address some of the economic problems precipitating attempts at admission. For example, one official reported that Read has started dispensing food baskets to persons seeking admission after they have run out of food.

Although it appears that hospitals are more willing to admit persons who do not rigorously meet the admission criteria delineated in the code, particularly when the individual lacks resources, others maintain that deflection policies are too rigid. Since state facilities tend to be full, successful deflection is important. Yet, failure to admit is perceived as having serious consequences. Informants frequently reported cases in which individuals would refuse to accept medical care and appear to be incoherent. They would not be admitted, however.

Generally, in the 20 percent of all cases where admission is refused at Read, an individual is referred elsewhere. Tellingly, for the undomiciled, this can be to a shelter. This is legal, although it is not legal to refer a discharged individual to a shelter program.

More frequently, it appears that referrals are made to community mental health centers or other community facilities. Theoretically, an appointment to such facilities must be made within three days (although this may still be too long for some people). However, more time may elapse when community agencies are busy. An additional problem is that many individuals have, as part of their mental illness, an inability to keep track of time or keep appointments. If they fail to appear for the initial appointment, according to informants, it is likely that they will be dropped from a center's caseload. Workers at the state hospitals complain in fact that the centers do not view anyone as their client until they reach the front door of the center for the first time. Another informant in the community noted that there is often only a paper transfer from the hospital to the CMHC. Many individuals do not come and no follow up is done.

Some street workers believe that the deflection centers could be more aggressive, especially when individuals sent to them attempt to leave. Although the centers have no authority to hold someone for observation, some informants believe that a stronger attempt might be made to keep someone there. Another commonly expressed concern was that the centers vary widely in policy. Many, if they admit individuals, tend to release them after 21 days when their state funding is used up regardless of the individuals' need for further care.

Discharge Policies. Read generally keeps individuals about three weeks. Most stay slightly less time but there is a small group that remains in the facility for a longer period. Discharges, in theory, should be to a specific place--back home, to an officially licensed facility, or to a friend or relative. As discussed previously, individuals cannot be "dumped on the streets." Rule 125 of the Illinois Revised Statutes (Chapter 91 1/2) requires that discharges are planned before release and that the plan include aftercare as well. In addition, new requirements and procedures now attempt to set up a system whereby public benefits will be secured prior to discharge. (See Chapter 4 for more information regarding policy on SSI benefits.)

But practice apparently differs from theory. Legal advocates report that often post discharge planning visits which apply only to discharges to "community placements" (i.e., ICFs, SNFs and shelter care) are only cursory. Further, recent reorganization of the Department of Mental Health and Developmental Disabilities has resulted in greater confusion regarding the administrative entity responsible for follow-up.

Review procedures include monitoring programming, psychiatric services, care plans, and medical use. Although there are seven staff at Read who serve in this capacity, responsibility for all 350 to 400 people who are in community placements falls primarily to four workers. Each has an active caseload of 70 to 80 people at any point in time. Consequently, intensive intervention may be impossible.

The referral system for those not discharged to community placement presents other problems. One informant noted that her community mental health center had a "working agreement" with the state institution and worked with a liaison at the facility to plan for people who were discharged to the community. She felt that the hospital assumed the community mental health center could do everything, however, and that hospital staff tended to be unrealistic about time and preparation. They might decide to release someone within an hour even though it was difficult for the center to coordinate things with the liaison that quickly. Our informant reported that at one point, the center was having so many coordination problems that staff had insisted that the liaison be given a pager. When the liaison was sick and there was no one to coordinate releases, patients were just discharged.

Such practices have implications for homelessness. People who need assistance may "fall through the cracks" either because they are not discharged to a "community placement" so there is no follow-up, or because workers are too busy to do very much for those who are referred to placements. Some, "dumped" back into the community, may subsequently become homeless. For those in placements, the lack of monitoring may mean that problems go unnoticed. When these problems threaten the success of a placement, homelessness may result.

There are also situations in which planning cannot occur. Unless someone is formally committed and still subject to commitment at discharge, he or she can refuse placement and aftercare treatment. Individuals who do not want to comply with discharge plans or those who do not want to go to an aftercare placement can simply refuse to cooperate. They must be discharged anyway. Further, some informants believe that since individuals cannot be discharged unless it is to a specific location, certain homeless individuals who wish to leave the hospital use shelter addresses. This enables them to get around workers who might keep them in the institution for a few more days.

In an attempt to address this problem, the Governor's Task Force on the Homeless recommended that the Department distribute a directive to all state facilities encouraging staff to avoid discharges to shelters and requiring that when such discharges were unavoidable, facility staff initiate linkage to case coordination programs for at least short-term service prior to discharge. Further, the Task Force recommended that this linkage be confirmed within 24 hours. The Department drafted such a directive in 1986 in response to these recommendations (Illinois Department of Mental Health and Developmental Disabilities, 1986a).

Residential Programs. Although there are conflicting impressions among informants and the literature as to whether discharges to nursing homes and shelter care have increased in the past few years, there is no doubt that the number of residential beds outside of nursing home and shelter care (as mentioned before, distinct from shelters for the homeless) has grown. One study links a decline in nursing home placements to this growth (Wallen, 1984).

But nursing homes and shelter care continue to be used, and there is some concern among those in the field about the appropriateness of such placements. According to one informant, by the early 1980s the state was forced to adopt a geriatric model for care in order to use available funds. Nurses aides, directors of nursing, and other medical personnel were needed. Some facilities which had served younger mentally ill persons were forced to close or take money away from programs for such residents.

In other cases, facilities which could not meet state standards simply reduced the level of care. Rather than considering themselves ICFs, one informant noted, they became room and board facilities. As such, they are not specifically licensed by the state. The facilities may still have mentally ill individuals in them. These individuals may pay through SSI grants but the Department of Mental Health and Developmental Disabilities has no oversight of the care available in the facility.

The demands for intensive programming within ICFs as a prerequisite for funding may have implications for homelessness. Many believe that such required programs are too difficult for some clients. Two facility operators reported that the paranoid, alcoholic, secretive individual, as well as the disruptive, do not do well in facilities. As noted, large caseloads may make intensive monitoring difficult. Thus, in cases where a "proper fit" is not made, persons may leave a community care facility because of an inability to adjust to program demands, but may have no residential alternative. They may also lack financial resources because the SSI payments may be made directly to the care facility. In such cases, homelessness may occur.[1]

An additional factor, related to homelessness is that the number of placements available, particularly for some kinds of clients, is shrinking. Some individuals who have had problems before may, over time, become "blacklisted" and have problems obtaining a placement again. According to one informant, ICF operators know each other so that if an individual is a troublemaker, it will be difficult for him or her to enter any facility. Those who have set a fire or who have an alcohol problem as well as mental health problems are the most difficult to place. Several informants specifically noted the lack of placements and services for dually diagnosed individuals. This was seen by them as particularly problematic because they felt that many in this category were homeless. Further, as Medicaid requirements have become more stringent, facilities have become reluctant to accept the mentally ill in general unless they have some medical problem or are over 65. Informants report that some facilities are unwilling to accept any mental health clients regardless of whether or not they meet these criteria. Finally, funds for other community residential programs still remain limited. Thus, the options for people who need aftercare or supported living environments are shrinking. This deficit may make homelessness more likely in some cases.

---

[1] The Department has indicated that it is attempting to address some of these problems, particularly those related to "improper fit." Department officials have developed a requirement for a new level of long-term care--ICF-MI Psychosocial Rehabilitation--in response to a 1985 Department study assessing the mental health needs of persons in nursing care (see Illinois Department of Mental Health and Developmental Disabilities, 1986a, p. 30, for a description of this level of care). Standards for care have been delineated and attempts to implement and secure support for this level of care are currently underway.

Community Treatment Centers. Despite the increase in the number of alternative residential programs funded by the Department in the 1980s, most persons still appear to be discharged either to their own or to their families' care. For example, in FY 1983, of the 18,817 MI discharges from state facilities, approximately 8 percent were discharged to licensed long term care facilities, 4 percent to structured community residential programs funded by the state, and 88 percent to themselves or to their families (Wallen, 1984). Consequently, most people who are discharged from hospitals, if they continue to have contact with the mental health system following discharge, will do so through community programs.

Aftercare provided by community agencies may be critical in relation to homelessness. The availability of necessary treatment as well as supportive services provided by many community agencies, including assistance with the tasks of daily living, linkage to vocational training, housing, and financial benefits all may enable individuals to function in the community and remain domiciled. However, informants noted that in general, the community mental health centers and many community programs are not as effective as they might be in treating discharged persons or the chronically mentally ill in the community. Informants note that one problem with many of the community-based centers is that those located in areas where there are few chronically mentally ill living apart from their families, do not have a high level of programming. There are legal criteria which require these programs to deal with formerly institutionalized persons, but because they do not see sufficient numbers of deinstitutionalized people, staff do not know exactly what to do. Some problems also occur when the community mental health centers are far away from the population or in an ethnically different neighborhood. Some who need help may be reluctant to seek services or may not receive those services which would be most beneficial. It is possible that without such services, certain persons are more likely to become homeless.

As discussed, a number of comprehensive community-based programs designed specifically to meet the needs of the chronically ill do exist, but informants complained about access to them. Some of these special programs for the homeless and chronically mentally ill are often full. Further, when DMH/DD funds are used, certain programs which might be most useful to the chronic mentally ill and the homeless among them require at least three hospitalizations in the last year as a criteria for service. Given admission criteria and deflection policies, it is possible that many who might benefit from these more intensive programs never build up the "track record" needed to enter them.

Apart from restrictions related to institutional history, there is also evidence that those communities with populations at greatest risk for homelessness are those which have the fewest community services. Comparing funding to grant-in-aid agencies on a basis of dollars received per 1,000 persons in poverty within city planning areas, researchers at the University of Illinois found that those planning areas with large poverty rates rarely received adequate funding. The authors note:

> Our findings suggest that there is considerable inequity across planning areas in the community-based services that can be offered to the poor through public funds. There was no relation in FY 86 funding patterns between the intensity of need and the capability of a planning area to respond to the mental health needs of its poor residents. [Further] Twenty-two of the 26 Chicago planning areas showed medium to intense needs for expanded community-based services (University of Illinois at Chicago, 1987a, pp. 4-5).

Of further concern are the services available to those who use community mental health facilities. The recent report on state hospital utilization in Chicago notes that those who sought help from a community resource two months prior to hospitalization typically saw a psychiatrist twice for less than an hour each time (Lewis et al., 1987). In general, the help received focused on medication. Sixty-four percent received no help with money or housing problems even though these problems were often identified by subjects as the reason for requesting admission to the hospital (Lewis et al., 1987). These findings suggest that often the services provided in community agencies are inadequate to meet the needs of those who have practical problems in addition to their mental health difficulties. The failure to provide for practical needs may eventually precipitate homelessness for some mentally ill individuals.

Some informants also criticized the crisis teams that are attached to community mental health centers. One worker claimed that they are not easy to reach and often do not respond to a call for days. For example, one pregnant homeless woman who was living under a bridge seemed mentally ill and denied being pregnant. There was fear that she was a danger to her unborn child. To protect the baby, community workers wanted to have her committed just before she had the baby. However, when the crisis team from the community mental health center was requested to come, they could not coordinate with the community workers in time. The woman was lost to the workers and eventually had the baby in a public rest room. In general, one worker said, only the cooperative clients can remain in the community mental health system.

Others we spoke with noted that the ICFs and the community mental health centers do not relate well to each other. The latter believe that the ICFs have staff to handle all problems. The result is that many ICF clients do not get needed community services. As noted previously, similar conflicts exist between hospitals and community centers. Individuals may go unserved because of the disagreement as to what agency is responsible for seeing that their needs are met.

The community mental health centers are often underfunded. They have small staffs compared to the number of clients they are expected to serve and they vary in their commitment to the chronically mentally ill. Many believe that they do not have the legal power to force individuals into treatment even when treatment may be essential to maintaining the individual in the community and/or keeping him domiciled. In other cases, they may speak the rhetoric of choice but in actuality lack the staff to try to convince the reluctant that they need help. As discussed previously, a number of centers have innovative programs designed to serve the chronically mentally ill. Further, at least some recognize the need to provide concrete resources and assistance with daily living skills as well as counseling services to some of their clients.

The Department also seems to be making efforts to address some of these problems. Reportedly, 1,614 new case management slots were funded in FY 86 including services for persons in nursing homes and shelter care (Illinois DMH/DD, 1986b).

In addition, in the fall of 1987, The Department secured federal money, to be matched by state or local funds, specifically for services to the homeless mentally ill. Unfortunately, the funds are limited. In the city of Chicago they will be used to support two long-term case management units, a city-wide mobile outreach and assessment unit, a crisis stabilization facility and one extended treatment and rehabilitation residence.

SUMMARY AND CONCLUSIONS

The information provided by informants about the mental health system and its implications for homelessness can be summarized in the following conclusions:

1. Nursing home and shelter care, which are still the primary community residential alternatives for mentally ill persons, are becoming more limited. Further, their appropriateness for many mentally ill persons is questionable.

2. Other residential alternatives appropriate to the needs of the mentally ill are severely limited and access is a problem. One hindrance for many who might benefit from intensive community programs is that services are limited to those who meet the criteria of three hospitalizations in the past year or five altogether. Additionally, there is some indication that persons in high poverty areas have less access to community services.

3. The hospital may be used as a resource of last resort for those who have economic problems. Hospital staff are rarely able do much to address problems, however, when admission is sought because of material deprivation.

4. Conversely, an emphasis on keeping admissions low and a too stringent application of the mental health code to all cases may prevent some of those who need help from obtaining it. This may be particularly devastating because community support programs, particularly the more comprehensive ones, are usually contingent upon hospitalization.

5. There are conflicting expectations regarding the role of the institution, aftercare facility and mental health center in linkage and in the provision of support and counseling services. The result is that frequently, linkages are never made and services never provided.

6. Despite the best intentions of discharge staff who, admittedly, maintain large caseloads, there are some ways in which individuals can return to homelessness directly from a mental hospital. This is especially true when admissions are not involuntary or a specific discharge to community care is not planned.

7. Although there seems to be an increasing attempt to meet the concrete needs of the mentally ill by community programs, funds for this support are still insufficient for some agencies.

8. Attempts to ameliorate problems leading to homelessness focus on attending to concrete needs, mediating conflicts, or attempting to alter lifestyles that may result in homelessness. However, few programs emphasize these services alone and many continue to stress psychotherapy equally if not more than they do the provision of concrete assistance.

DATA ANALYSIS

The survey data helps to assess the validity of some of the arguments about mental illness, hospitalization and homelessness. The focus is primarily on the role of institutionalization. Thus, for the bulk of this analysis, the sample is divided according to those who reported that they had been hospitalized at least once in their lifetime and those who had not. Much of the discussion centers on whether those in the institutionalized group who became homeless had different traits or were treated differently during or after hospitalization and whether these differences might suggest a reason for their homelessness.

But, institutionalization is not proof of mental illness. To assess issues related to the relationship of mental illness to homelessness and lack of care, we include some assessment of the whole sample, using an objective measure of mental health. We ask whether the homeless were more likely to have untreated mental health problems.

Most of the analysis compares the ever and never homeless. This was done primarily because in most cases, the factors contributing to homelessness, if they existed, should have been important regardless of whether or not the individual was currently homeless. In other instances, because we were concerned with the impact of a factor in the present or because we asked about current experiences, it was appropriate to compare the currently and never homeless. This is noted in the relevant sections.

Timing of events cannot always be measured, however, making the causal pattern hard to determine. Thus, at times, we broke the hospitalized sample into groups according to whether they had been homeless prior to or following their last hospitalization. This allowed us to assess if there were differences in the services received at discharge depending upon whether or not the respondent was already homeless. It also enabled us to identify possible effects of hospitalization.

The questions which were included in the mental health section of the questionnaire were certainly sensitive ones. It is possible that all the information we obtained was not completely valid. However, the proportion of hospitalized respondents is similar to numbers reported in other studies, particularly with respect to the homeless (Morse et al., 1985; Rossi, Fisher and Willis, 1986). Further, we have no reason to think that if information was inaccurate, there was any bias in terms of the information from one group being more valid than data from another. Thus, we feel that our comparison is still a fair treatment of the role of hospitalization.

Demographics

Ever versus Never Homeless Hospitalized Respondents. To get a better idea of whether hospitalized persons who became homeless differed in some basic way from those hospitalized persons who were not homeless, we compared demographic data for the groups. We assumed that any existing differences might enable us to better understand if some persons who were hospitalized became homeless for unusual reasons. Comparing hospitalized homeless with not homeless hospitalized persons allowed us to see if demographic differences or differences in commitment patterns might indeed "cause" homelessness.

Table 3.1 presents demographic data on hospitalized respondents as a whole and compares the never versus ever homeless within this group.

In general, the group is comprised of poor black males in their late 30's and early 40's. Most have been married and few have experienced institutional placement as children. Although our sample is slightly older on average, this profile is consistent with the characteristics of hospitalized persons reported in a recent study on hospital use released by the Center for Urban Affairs and Policy Research at Northwestern University (Lewis _et_ _al_., 1987).

The table reveals that for the most part, among hospitalized respondents, the homeless do not differ greatly from the never homeless. There are some notable exceptions, however. First, there are significantly more males among the homeless compared to the never homeless. In addition, among those who have been hospitalized, the homeless tend to report living alone in both their last living situation and their current one more often than do those who have never been homeless. This difference is statistically significant for respondents' current living situations although it is not as strong and not quite statistically significant with regard to their last living arrangement.[2]

---

[2] We also compared the hospitalized homeless with the never hospitalized homeless to better clarify the impact of hospitalization on homelessness. Again, there are very few significant differences between the two groups. The never hospitalized were more likely to have had a drink in the past 30 days but the hospitalized homeless were slightly more likely to report binge drinking. These differences were not statistically significant and suggest that there is little relationship between hospitalization, homelessness and drinking behavior. The one area in which the two groups differed was, again, in whether respondents had lived alone. Once more, hospitalized persons tended to live alone significantly more often than those homeless who were never hospitalized. These findings indicate that homeless people look very similar to each other regardless of whether they have been hospitalized for a mental illness. (See Appendix Tables A1 and A2 for this data.)

Table 3.1

Selected Demographic Characteristics of Hospitalized Respondents-Never Versus Ever Homeless

	Total Hosp. Sample	Never Homeless	Ever Homeless
Mean Age:	38.22 (85)	40.78 (16)	37.65 (69)
Race:			
Black	63.9% (84)	69.1% (16)	62.7% (68)
Other	36.1% (84)	30.9% (16)	37.3% (68)
Sex:			
Male	64.7% (84)	39.6% (16)	70.4%* (68)
Female	35.3% (84)	60.4% (16)	29.6% (68)
Marital status:			
Ever married	52.1% (84)	58.6% (16)	50.6% (68)
Never married	47.9% (84)	41.4% (16)	49.4% (68)
Mean number of years of education:	11.04 (85)	11.17 (16)	11.01 (69)

(Continued on next page)

Table 3.1--Continued

	Total Hosp. Sample	Never Homeless	Ever Homeless
Highest weekly individual income (in 1977 dollars)	$232.79 (68)	$198.56 (9)	$238.33 (58)
Mean time worked as % of total time since respondent first worked and present	50.7% (85)	45.9% (16)	51.8% (69)
Percent ever in childhood out of home care	16.2% (85)	6.9% (16)	18.4% (69)
Percent living in female headed families in most recent living arrangement	14.6% (83)	13.8% (16)	14.8% (67)
Percent reported to be living alone in their current living situation	71.4% (83)	37.8% (16)	79.2%** (67)
Percent reported to be living alone in their last living situation	56.0% (79)	34.5% (15)	60.9% (64)
Percent who consumed any alcohol in last 30 days	50.4% (85)	41.4% (16)	52.4% (69)
Percent of sample who go on drinking binges	23.2% (84)	20.7% (16)	23.7% (68)

Numbers and percents are rounded.

For ever homeless and never homeless comparison:
* $p < .05$
** $p < .01$

Patterns of Hospitalization

A basic issue in discussions about the mentally ill homeless is whether or not hospitalization, or the lack of it, "causes" homelessness. In essence, the question is whether mental illness leads to homelessness for some people regardless of whether they are hospitalized or whether a lack of treatment in light of apparent pathology is the causal agent.

One way of addressing these arguments is to look at the number of hospitalizations among the homeless in comparison to the never homeless. A higher hospitalization rate among the homeless might indicate greater pathology which in turn may result in homelessness, regardless of whether hospitalization occurs. But, if we equate hospitalization with treatment, a lack of hospitalization might suggest unmet treatment needs, resulting in homelessness. Further, if community treatment is tied to the number of hospitalizations, it is possible that those with fewer hospitalizations fail to get necessary assistance. Homelessness may be one outcome.

In analyzing the relationship between hospitalization and homelessness, we must consider first, whether the homeless are more likely to be hospitalized and second, whether among all hospitalized persons, the homeless have different use of the hospital that might suggest a reason for homelessness.

There is a significant relationship between the likelihood of having been hospitalized and homelessness. The ever homeless are significantly more likely to have been hospitalized for psychiatric treatment at some time; 20.0 percent of the ever homeless have been hospitalized versus 8.7 percent of the never homeless ($X^2 = 11.24$, $p < .01$). This suggests that mental health problems and/or treatment for such problems may lead to homelessness.

Table 3.2 shows the mean number of hospitalizations per group, for the homeless and never homeless who have been hospitalized. The table shows that the groups do not differ significantly; on average, both groups report about 4 hospitalizations in their lives. This indicates that although the homeless are more likely to be hospitalized in comparison to all nonhomeless in the sample, when compared to other hospitalized persons, their pattern of hospitalization does not differ. It is therefore difficult to conclude that they receive less or more treatment than other persons whose mental health problems require hospitalization. While both groups have had more hospitalizations, on average, than the general population, it is also clear from the table that most individuals in both groups have had fewer than 5 hospitalizations--the number needed in order to be eligible for many intensive programs. A smaller proportion of the homeless compared to the never homeless, in fact, have more than five hospitalizations. They are thus less likely to be eligible for the allegedly superior programs.

Sequence of Homelessness and Hospitalization. In order to get a better idea of the causal chain involved in the relationship between homelessness and hospitalization, we sought information about the timing of the first hospitalization and first spell of homelessness. By conservative estimates, assessment of each respondent's status at the time of this first hospitalization should be a good indicator of the causal connection between homelessness and hospitalization. If the first spell of homelessness followed hospitalization or related events, we reasoned that hospitalization could be a possible "cause." However, if homelessness preceded hospitalization, a stronger case could be made that hospitalization was an effect of

Table 3.2

Mean Number of Hospitalizations and Proportion with 5 or more--Ever versus Never Homeless

	Total Hosp. Sample (79)	Never Homeless (13)	Ever Homeless (66)
Mean number of hosp.	3.98	3.62	4.06
Range	1-20	1-10	1-20
Percent with 5 or more hosp.	26.2%	40.1%	23.4%

Numbers and percents are rounded.

homelessness. Perhaps homelessness led to mental health problems requiring hospitalization or perhaps the hospital was used for shelter.

The sub-sample of homeless hospitalized respondents was divided according to whether their first spell of homelessness preceded or followed their first hospitalization. In most cases (61.8%), homelessness followed the first hospitalization. But these events were not close in time. Most (n=31 or 52.5 percent) of the sub-sample were hospitalized more than 1 year prior to their first spell of homelessness. Another 32.2 percent (19) were first homeless more than 1 year preceding their first hospitalization. Fifteen percent of the sub-sample in fact, were first hospitalized ten years or more prior to their first homeless spell. Only 7 people were hospitalized within 1 year of their first spell of homelessness (11.9%) and only three of these seven reported becoming homeless and hospitalized at the same point in time.

In sum, it appears that with few exceptions, homelessness, at least initially, was not closely related in time to the first hospitalization. While there is some indication that hospitalization tended to precede homelessness and might thus be considered a "cause," homelessness in general did not commence immediately upon release. Given the time gap, it is difficult to conclude that homelessness--at least an initial spell--was the direct result of being "dumped" into the community.

Impact of Hospitalization. Lastly, we asked whether hospitalization had an impact on homelessness. We wanted to know if someone who was mentally ill and hospitalized was less likely to become homeless compared to someone who had no institutional history but showed a need for treatment.

In order to address this issue, we performed a logistic regression which looked at these relationships.[3] Our analysis of the impact of hospitalization in cases where mental illness was indicated showed that there was no relationship. In effect, those with mental health problems might or might not become homeless regardless of whether or not they are hospitalized. This suggests that while hospitalization does not "cause" homelessness, it also does not prevent it.

Mental Health Problems

Just as we can ask whether the homeless and never homeless who have been hospitalized differ on demographics or institutional histories, it is also possible that the homeless have different problems. This difference may explain why some hospitalized persons become homeless while others do not. To explore this possibility, we used two measures; the first was the respondent's report of what problems he or she was told were present at admission. The second was an objective instrument used to assess the mental health status of the entire sample.

Respondent were asked what they were told their problem or problems were at the time they were hospitalized. Possible answers they could select included schizophrenia, depression, anxiety problems, personality problems, nervous problems, organic mental disorders, alcohol/drug related problems or

---

[3] This analysis was performed comparing the ever homeless and never homeless for the entire sample. Logistic regression, which is discussed more fully in Chapter 6, was utilized. All of the standard factors which were loaded for the comparisons between these two groups, as explained in Chapter 6, were used first. Next, an interaction term which was comprised of GSI score and whether or not hospitalization occurred was added to the equation. It did not add significantly to the overall chi-square for the equation. Thus, we concluded that no relationship between hospitalization and homelessness, in light of mental health problems, existed.

"other" problems. Respondents could give up to three answers. Although most gave only one answer, 13 people reported two problems but only one person reported three.

Table 3.3 contains the breakdown of problem types by group. Despite popular opinion and reports in the literature, most of the people who were hospitalized apparently did not suffer from schizophrenia. Ironically, never homeless people reported this as a problem more than the homeless but even for them, it was not a common problem. No statistically significant differences existed between groups in this category.

In interpreting these data, it is important to point out that the answers which were given were what people remember or were told. "Nervous disorder" and "other" were mentioned by quite a few respondents, especially among the homeless. Such catchall categories may have certainly included schizophrenia as well as any of the other problem types. Therefore, it is possible that more respondents, particularly homeless respondents, were actually schizophrenic but were not specifically told that this was their problem. Our basic finding, however is that there does not appear to have been any particular problem with schizophrenia "causing " homelessness; incidence of schizophrenia was not higher among the homeless; it was not extremely prevalent given the poverty of the sample nor was it more common than any other pathology.

Depression was a frequently cited problem for both groups as was an alcohol and/or drug related problem. There were slight differences between the groups as to which of these two was mentioned more often. Although the numbers are very small, the data suggest that the homeless do not seem to

Table 3.3

Reported Problem at Admission
Never Versus Ever Homeless

Problem Category	Total Hosp. Sample (77)	Never Homeless (14)	Ever Homeless (63)
Schizophrenia	10.9%	15.7%	9.8%
Depression	26.2%	29.4%	25.5%
Alcohol/ Drug Problem	27.4%	23.5%	28.2%
Anxiety Problem	5.6%	0%	6.9%
Personality Problem	4.2%	7.9%	3.4%
Organic Mental Problem	3.9%	7.9%	3.0%
Nervous Problem	21.7%	7.9%	24.8%
Other	19.0%	15.7%	19.7%

Numbers and percents are rounded.

Up to three answers were possible for each respondent. Therefore, percentages are greater than 100.

No significant differences existed between groups.

have significantly more drug or alcohol related problems as a proportion of all problems in comparison to the never homeless. The homeless do cite "nervous problems" more often than the never homeless but apart from this, no profound differences between the groups seem apparent and none of the differences noted were significant.

In addition to obtaining information about problems at admission from respondents, a 53-item self-report symptom inventory was administered to the entire sample. The Brief Symptom Inventory (Derogatis and Spencer, 1982), or BSI, consists of 9 scales which look at different symptom dimensions and three overall global ratings. The global ratings include: 1) the Global Severity Index (GSI), the most sensitive single indicator of the respondent's level of distress, averaging information on numbers of symptoms and their intensity to arrive at a global score; 2) the Positive Symptom Total (PST), a measure of the number of times in which symptoms exist; and 3) the Positive Symptom Distress Index (PSDI) which measures intensity alone and provides information on the average level of distress experienced by a respondent who has distress on any item (Derogatis and Spencer, 1982). In addition to the information provided by the scales, researchers have used GSI scores to develop a screening measure for psychiatric disorders and have determined a cutoff point which indicates whether someone's symptomatology is extreme enough to warrant their needing psychiatric treatment.

Before proceeding with the analysis, it is important to point out some limitations on this data and on our assumptions. First, we only had one opportunity to administer the instrument--following the last hospitalization. We assumed that the symptoms being measured were relatively stable ones that should have remained constant over time. It should not therefore have mattered when the instrument was administered. It is possible, however, that symptoms did change and initial differences between groups existed prior to institutionalization. Because of the hospitalization, these differences could have disappeared. A more difficult problem relates to the direction of any relationship. It is possible that homeless people are more mentally disturbed and this may lead to homelessness, particularly if the homeless do not receive the services they need to improve their mental health. However, an alternative hypothesis which is popular with many is that the homeless do not differ initially. Instead, they appear to be more "mentally ill" or more symptomatic as a result of their homelessness. Thus, it is the condition of homelessness itself which leads to mental illness rather than the opposite. Again, because we do not have a measure of symptomatology for persons before and after homelessness, we cannot draw any strong conclusions about the direction of any relationships which appear. But, some of our comparisons allow us to shed a bit more light on these issues. Finally, while high scores on the BSI may indicate mental instability, they may not, given the reality of the sample, be a sign of mental illness.

Table 3.4 provides information on the mean BSI scores for hospitalized respondents. It compares the never and ever homeless. In all cases with the exception of the somatization and depression scales, we can see that the homeless scored higher on average. Nonetheless, among the present sample, there were no strong statistically significant differences between the groups on these or any other of the scale's dimensions.

Table 3.5 examines the proportion of those who have been hospitalized who could use treatment according to their GSI scores. This table shows that among those who were hospitalized, the majority of respondents fell

Table 3.4

Mean BSI Scores for Hospitalized Respondents:
Ever Versus Never Homeless Persons

SCALE	Total (84)	Never Homeless (16)	Homeless (68)
SOMATIZATION	.90	1.00	.88
OBSESSIVE COMPULSIVE	1.31	.94	1.39
INTERPERSONAL SENSITIVITY	1.27	.96	1.34
DEPRESSION	1.24	.99	.99
ANXIETY	1.27	1.04	1.33
HOSTILITY	1.09	1.07	1.10
PHOBIA	1.06	.84	1.10
PARANOIA	1.03	1.24	1.65
PSYCHOTICISM	1.01	.97	1.02
ADDITIONAL ITEMS	1.28	1.13	1.32
GSI	1.19	1.01	1.23
PST#	28.23	26.95	28.52
PSDI+	2.04	1.76	2.10

Numbers and percents are rounded.

#There was one more person included in the analysis from the homeless group for this scale.

+There was one less person in the never homeless and homeless groups on this scale.

Table 3.5

Proportion Above and Below the 90th Percentile on the GSI for Hospitalized Respondents: Ever Versus Never Homeless

	Total (83)	Never Homeless (16)	Ever Homeless (67)
Score is below the cutoff point indicating need for treatment	30.9%	44.8%	27.7%
Score indicates a need for treatment	69.1%	55.2%	72.3%

Numbers and percents are rounded.

into the treatment category. Thus, even though these individuals had been hospitalized, most still needed further treatment regardless of whether they had ever been homeless. A greater proportion of the homeless were likely to fall into the treatment category as compared to the never homeless. However, there was no significant difference between the members of the hospitalized group.

In order to get a better understanding of whether mental illness is a causal factor in the development of homelessness, we compared the never, previously, and currently homeless on the BSI. This comparison is presented in Table 3.6. We reasoned that if mental illness led to homelessness, it was possible that improved mental health might help one escape. Therefore, the previously homeless might show less symptomatology than the currently homeless.

The data suggest that mental illness is an enduring trait regardless of homeless status. Looking at the table, we see that the currently homeless often scored lower than the previously homeless on a number of the scales and global measures. The previously homeless, despite their no longer being homeless, still seem to be quite symptomatic; on some scales, even more so than the currently homeless. There is some possibility that because of our sampling methods, our group of previously homeless respondents was more disturbed than is usually the case among all homeless. But these data still suggest that mental illness is a trait independent of homelessness. At the same time, even if mental illness does not "cause" homelessness to occur, it is possible that those with mental health problems have a more difficult time coping. This difficulty may, at times, increase the likelihood of homelessness, especially when one's resources are limited. As the data

Table 3.6

Mean BSI Scores for all Hospitalized Respondents by Group:
Never, Previously and Currently Homeless

SCALE	Never Homeless (16)	Previously Homeless (33)	Currently Homeless (35)
SOMATIZATION	1.00	.77	.98
OBSESSIVE COMPULSIVE	.94	1.40	1.38
INTERPERSONAL SENSITIVITY	.96	1.45	1.23
DEPRESSION	.99	1.18	.94
ANXIETY	1.04	1.25	1.40
HOSTILITY	1.07	1.13	1.07
PHOBIA	.84	1.13	1.07
PARANOIA	1.24	1.65	1.64
PSYCHOTICISM	.97	.85	1.17
ADDITIONAL ITEMS	1.13	1.29	1.34
GSI	1.01	1.19	1.26
PST#	26.95	26.87	30.13
PSDI+	1.76	2.14	2.06

Numbers and percents were rounded.

#There was one more person included in the analysis from the previously homeless for this scale.

+There was one less person in the never and previously homeless groups on this scale.

suggest, the mentally ill may thus go in and out of homelessness. Mental illness may also make life harder when homelessness does occur.

Conversely, we can ask whether homelessness is a causative agent in deteriorating mental health. Again, if this were so, we might expect the previously homeless to be less symptomatic when compared to the currently homeless, which they do not appear to be. Since the previously homeless in our study may be more disturbed than is usually the case, comparisons between these two groups may be problematic. However, if we compare the currently homeless with the never homeless in Table 3.6, we can see that the former scored higher, on average, than the latter, particularly on the GSI. Further, the currently homeless score higher than both the previously and never homeless in areas we might expect, such as anxiety, given their homeless status. While none of these these differences were statistically significant, they do suggest that homelessness has some impact on mental health even if it is not the initial or only causative factor in mental illness.

These data also substantiate the finding that the hospitalized groups are quite similar in their level of symptomatology. A comparison of the currently and never homeless who were hospitalized in relation to the cutoff point for treatment indicated no significant differences between groups. As Table 3.7 shows, the majority of persons in both groups fell into the treatment-needed category.

Discharge and Outpatient Treatment Patterns

Practices related to living arrangements after discharge and outpatient treatment referral may be critical to understanding how homelessness can

Table 3.7

Proportion Above and Below the 90th Percentile on the GSI for Hospitalized Respondents: Currently Versus Never Homeless

	Total (50)	Never Homeless (16)	Currently Homeless (34)
Score is below the cutoff point indicating need for treatment	32.4%	44.8%	26.8%
Score indicates a need for treatment	67.6%	55.2%	73.3%

Numbers and percents are rounded.

result after hospitalization. As discussed in the first part of this chapter, failure to make adequate living arrangements after discharge may lead to homelessness. This is especially true when individuals need special settings to cope outside of the hospital and these are not provided. Similarly, some theorists posit that the lack of linkage to outpatient care or the failure of certain individuals to seek treatment after hospitalization may result in homelessness. If these are important factors in the etiology of homelessness, we can expect the homeless to receive fewer referrals for aftercare or treatment and/or to have fewer discharge plans made for them. Further, proponents often maintain that compliance with medication regimens is critical in avoiding homelessness. In fact, outpatient treatment for many may consist of little more than monitoring medication (Lewis et al., 1987). We therefore hypothesized that if medication usage was a factor in homelessness, the hospitalized homeless would be less compliant than never homeless hospitalized respondents.[4]

In order to get a better understanding of the processes involved, we analyzed data on discharge practices and outpatient referrals several different ways. First, we compared the ever and never homeless to determine if different practices existed that might reasonably be considered "causes" of homelessness. Next, we divided the sample of hospitalized individuals according to whether or not someone's first period of homelessness in his life was prior to or following his last release. We then re-examined discharge practices. In this instance, comparing those who were homeless prior to their last hospitalization with those who were not yet homeless helped us to clarify the effect of recent planning on homelessness, especially for a small group of people who were released before becoming homeless. It also allowed us to see if discharge practices differed when a respondent was homeless before his last hospitalization. Additionally, we were able to better identify any possible effects of hospitalization on homelessness. Finally, we explored a number of intrapsychic and behavioral factors which might be responsible for observed differences. This enabled us to see if any possible differences could be explained by personal variation.

---

[4] It is also possible that the real issue, in terms of outpatient treatment, related to compliance with medication. That is, the impact of discontinuing treatment would be great because discontinuation would mean that medication regimens would be disrupted. We hypothesized that if this were so, we should see a relationship between those who reported that they no longer received or never received treatment and those who did not take their medication. Table A3 at the end of the report contains data comparing outpatient treatment and medication usage. The data show that there is no relationship between the variables. Most respondents did not have medication prescribed regardless of whether or not they received treatment. Further, most were still receiving treatment whether or not they were compliant with medication regimens.

Ever Versus Never Homeless. Respondents who had been hospitalized for mental health treatment were asked whether or not living arrangements were made for them upon release and the type of arrangements which had been made. As Table 3.8 notes, arrangements were more likely to be made for persons who were never homeless, but the difference was not quite statistically significant. It is possible that with a larger sample, a significant relationship would be found, especially since the difference is relatively large. When arrangements were made, most of the never homeless, 58.9 percent (or 6 people) had arrangements made with family. A smaller proportion, 39.8 percent (or 12 people) of the homeless had similar arrangements made but this was the resource used most often. About 20 percent of the people in both

Table 3.8

Living Arrangements upon Release: Never Versus Ever Homeless

WERE ARRANGEMENTS MADE FOR YOU TO LIVE SOME PLACE UPON YOUR LAST RELEASE?

	Total (81)	Never Homeless (14)	Ever Homeless (67)
Yes	50.0%	72.3%	45.1%
No	50.0%	27.7%	54.9%

WHEN ARRANGEMENTS WERE MADE, THEY WERE MADE AS FOLLOWS:

ARRANGEMENT	Total (41)	Never Homeless (11)	Ever Homeless (30)
With Family	44.7%	58.9%	39.8%
Group Home	3.9%	0%	5.3%
Hotel/Motel	7.2%	0%	9.7%
Own Home/Apt.	22.4%	20.6%	23.0%
Shelter	9.2%	10.3%	8.8%
Friend	4.6%	10.3%	2.6%
Halfway House	2.6%	0%	3.6%
Other	5.3%	0%	7.1%

(Continued on next page)

Table 3.8--Continued

WHEN ARRANGEMENTS WERE MADE, DID YOU GO?

	Total (40)	Never Homeless (10)	Ever Homeless (30)
Went	93.3%	88.6%	94.7%
Did Not Go	6.7%	11.4%	5.3%

AMONG THOSE FOR WHOM NO ARRANGEMENTS WERE MADE AT DISCHARGE, THE FOLLOWING LIVING ARRANGEMENTS WERE REPORTED:

ARRANGEMENT	Total (40)	Never Homeless (4)	Ever Homeless (36)
With Family	25.2%	26.7%	25.0%
Group Home	2.7%	0%	3.0%
Hotel/Motel	7.5%	0%	8.3%
Own Home/Apt.	31.3%	73.3%	26.5%
Shelter	4.8%	0%	5.3%
Friend	15.0%	0%	16.6%
Halfway House	0%	0%	0%
Other*	13.6%	0%	15.2%

Numbers and percents are rounded.

*Other included the following - 2 people reported staying in an abandoned building, 3 people reported that they stayed on the street.

groups were discharged to their own homes or apartments. Very few of the respondents in total were referred to group homes or halfway houses. There were no statistically significant differences between the groups with regard to the arrangements made.

One person in the never homeless group and two among the homeless reported that arrangements were made for them to reside in a shelter even though this is against DMH/DD policy. This is a very small number however. It appears that "dumping," if it occurred, was rare.

Respondents for whom no arrangements were made were asked where they went upon discharge. Again, because the number of respondents is so small, conclusions are tenuous. The never homeless usually (73 percent of all cases) went to their own homes or apartments. The remaining persons went to live with family. The homeless were more dispersed. About one-quarter reported that they went to live with family. Another quarter went to their own homes or apartments. But 5 (15.2%) respondents included under "other" reported staying in either abandoned buildings or on the street.

In almost all cases, when arrangements were made, respondents did go to these settings. As Table 3.8 shows, the never homeless, in comparison to homeless groups, were slightly less likely to go to the arranged place. But, the difference was very small and not statistically significant.

Table 3.9 presents a comparison of the never and ever homeless related to outpatient care. The table shows that the majority of persons in both groups were likely to be referred to treatment. The proportions for both groups in fact are almost identical. The never homeless were more likely to receive treatment when told about it but this difference was not statistically significant. Among those who did receive treatment, there was again

Table 3.9

Outpatient Treatment Patterns: Never Versus Ever Homeless

TOLD ABOUT OUTPATIENT TREATMENT:

	Total (79)	Never Homeless (15)	Ever Homeless (64)
Yes	80.3%	79.7%	80.4%
No	19.7%	20.3%	19.6%

OF THOSE TOLD, RECEIVED OUTPATIENT TREATMENT:

	Total (64)	Never Homeless (12)	Ever Homeless (52)
Yes	76.3%	90.7%	73.0%
No	23.7%	9.3%	37.0%

OF THOSE WHO RECEIVED TREATMENT, THOSE STILL RECEIVING IT:

	Total (50)	Never Homeless (11)	Ever Homeless (39)
Yes	51.1%	51.3%	51.1%
No	48.9%	48.7%	48.9%

Numbers and percents are rounded.

little difference between groups with respect to whether or not the respondent was still receiving it.

Finally, as Table 3.10 indicates, among those for whom medication was prescribed, both groups were equally compliant in terms of the proportion who always took their medication. The never homeless were more likely to be totally noncompliant compared to the homeless, however.

In sum, it appears that the ever homeless may be somewhat less likely to have arrangements made for them at discharge and this may "cause" homelessness (as the literature suggests) for a few. But, contrary to what the literature indicates, the ever homeless are just as likely to receive referral to outpatient treatment as the never homeless. They may be less likely to get treatment when referred but if they do receive it initially, they are as likely to continue it. Further, because the data indicate that the homeless were more likely to comply with treatment orders compared to the never homeless, it is unlikely that medication usage per se was an issue in the development of homelessness.

Those Who Were Homeless Prior to Their Last Release and Those Who Were Not. To more accurately assess the relationship between these variables and homelessness, a second set of analyses were performed comparing persons who were not homeless prior to their last release from a mental hospital and those who were homeless before they were last discharged. In total, 65.8 percent (n=38) of the homeless who were hospitalized were homeless prior to their last release. Twenty respondents (34.2%) were not yet homeless when last discharged from a hospital.

Table 3.10

Medication Usage Patterns for Hospitalized Respondents

	Total (30)	Never Homeless (6)	Ever Homeless (24)
Always take as prescribed	50.4%	50.0%	50.5%
Sometimes take as prescribed	42.6%	33.3%	45.1%
Do not take as prescribed	7.0%	16.7%	4.4%

Numbers and percents are rounded.

Table 3.11 shows that there was a difference between those who were already homeless and those who were not in relation to living arrangements at discharge. Those who were not homeless prior to their last hospitalization were much more likely to have arrangements made for them when compared to those who were previously homeless. But this is not statistically significant.

When arrangements were made, again, the groups differed in relation to where respondents were referred. Like the never homeless in Table 3.8, those who were not homeless prior to their last hospitalization were much more likely to have been referred to family (59.6 percent or 8 persons). Among the previously homeless, referrals to family were made for only 14.9 percent (n=2) of the respondents. Previously homeless respondents were more likely to have been sent to their own homes or apartments (40.8 percent or 6 persons in this group) in comparison to those who were not homeless prior to their last release (7.8% or 1 person from this group). None of these differences were statistically significant.

Regardless of where they were referred, respondents in both groups reported that they did go to the referral site in almost all cases. The two groups were virtually identical in this respect with 94.9 percent (n=15) of the already homeless and 93.4 percent (n=11) of those who were not homeless prior to their last hospitalization reporting that they did go to the referral site.

Among those who were not referred to a living situation upon release, there is some indication that those who were already homeless were less likely than others to go to family. Those not yet homeless were slightly more likely to go to their own homes. In addition, the "other" category

Table 3.11

Living Arrangements upon Discharge for Those Who Were Homeless Prior to Their Last Discharge and Those Who Were Not

WERE ARRANGEMENTS MADE FOR YOU TO LIVE SOME PLACE UPON YOUR LAST RELEASE?

	Total (57)	Homeless Prior To Last Release (37)	Not Homeless Before Last Release (20)
Yes	52.2%	38.8%	64.8%
No	47.8%	61.2%	35.2%

WHEN ARRANGEMENTS WERE MADE, THEY WERE MADE AS FOLLOWS:

ARRANGEMENT	Total (29)	Homeless Prior To Last Release (15)	Not Homeless Before Last Release (14)
With Family	36.8%	14.9%	59.6%
Group Home	5.6%	11.0%	0%
Hotel/Motel	10.4%	7.4%	13.5%
Own Home/Apt.	24.6%	40.8%	7.8%
Shelter	5.6%	11.0%	0%
Friend	2.8%	0%	5.7%
Halfway House	3.8%	7.4%	0%
Other	10.4%	7.4%	13.5%

(Continued on next page)

Table 3.11--Continued

WHEN ARRANGEMENTS WERE MADE, DID YOU GO?

	Total (28)	Homeless Prior To Last Release (16)	Not Homeless Before Last Release (12)
Went	94.2%	94.9%	93.4%
Did Not Go	5.8%	5.1%	6.6%

AMONG THOSE FOR WHOM NO ARRANGEMENTS WERE MADE AT DISCHARGE, THE FOLLOWING LIVING ARRANGEMENTS WERE REPORTED:

ARRANGEMENT	Total (29)	Homeless Prior To Last Release (23)	Not Homeless Before Last Release (6)
With Family	25.2%	23.6%	31.8%
Group Home	3.7%	0%	18.2%
Hotel/Motel	6.5%	8.2%	0%
Own Home/Apt.	32.7%	31.8%	36.5%
Shelter	2.8%	3.5%	0%
Friend	14.0%	14.1%	13.5%
Halfway House	0%	0%	0%
Other	15.0%	18.9%	0%

Numbers and percents are rounded.

again included those already homeless respondents who reported returning to the street upon their release.

Table 3.12 summarizes the data related to patterns of referral and utilization of outpatient treatment for those homeless prior to their last release and those not yet homeless. Analysis reveals there was no great difference in the likelihood that the respondent would be told about outpatient treatment. Eighty-one percent (n=30) of all those who were homeless prior to their last release were told about treatment. Seventy-four percent (n=13) of those who were not homeless before this last discharge were told as well. Similarly, of those who were told, 76.8 percent (n=23) of the already homeless and 69.3 percent (n=9) of those who were not yet homeless went to obtain treatment. There were no significant differences between the groups on either of these variables. The groups did apparently differ in whether or not they were still receiving treatment. Of those who had obtained treatment in the past, 69.8 percent (n=16) of those who were already homeless before hospitalization were still receiving treatment at the time of the interview. Only 7.8 percent (n=1) of those who were not homeless at the time of their last release answered yes to this question. The difference between groups was statistically significant.

The number of respondents included in the analysis at this point is quite small. But the data suggest that there may be a relationship between the discontinuation of treatment and homelessness. In accord with what is suggested in the literature and the information from informants, it is possible that in stopping treatment, those who were not yet homeless but who

Table 3.12

Outpatient Treatment Patterns by Whether or Not A Respondent was Homeless Prior to His Last Release from a Hospital

TOLD ABOUT OUTPATIENT TREATMENT:

	Total (55)	Homeless Prior To Last Release (37)	Not Homeless Before Last Release (18)
Yes	78.5%	80.6%	74.3%
No	21.5%	19.4%	25.7%

OF THOSE TOLD, RECEIVED OUTPATIENT TREATMENT:

	Total (43)	Homeless Prior To Last Release (30)	Not Homeless Before Last Release (13)
Yes	74.5%	76.8%	69.3%
No	25.5%	23.2%	30.7%

OF THOSE WHO RECEIVED, STILL RECEIVING TREATMENT:

	Total (33)	Homeless Prior To Last Release (23)	Not Homeless Before Last Release (10)
Yes	50.8%	69.8%	7.8%
No	49.2%	30.2%	92.2%**

Numbers and percents are rounded.

For the previously and not yet homeless comparison:

**p < .01

presumably still needed treatment, fell into homelessness. But, there are other possibilities. For example, it may be that becoming homeless made it more difficult for these respondents to continue obtaining treatment.

These data also provide little evidence that those who are not yet homeless lack aftercare plans. Rather, it appears that it is the already homeless who are less likely to have living arrangements made for them. In accord with the information provided by informants, we can speculate that this may be because those who are already homeless are more likely to refuse help. As some noted, they may wish to return to the street or they may find the housing alternatives which are available to be undesirable. Possibly, as was suggested, these individuals may be more difficult to place.

It is also conceivable that those who were homeless before their last hospitalization had no homes to which they could be sent or fewer resources such as family or friends to whom staff could refer them at discharge. Analysis of the number of friends and family the homeless reported seeing in the past 30 days addresses these issues to some extent and is explored in more depth in Chapter 5. However, a comparison of respondents who were hospitalized and those who were not reveals that significant differences did exist between groups with respect to the number of family members they had seen in the past thirty days ($F=5.22$, $df = 1/516$, $p < .05$). Hospitalized respondents had seen significantly fewer family members on average. This lends support to the possibility that family were less of a resource to the homeless upon discharge compared to those who were never homeless.

Intrapsychic and Behavioral Factors Related to Discharge Plans and Treatment Patterns. Before we conclude that the homeless are less likely to have living arrangements made for them, we need to ask whether there is a possibility that respondents for whom no arrangements were made differed in some way from those who were referred to a living situation upon discharge. It is possible that in addition to being harder to place because of a lack of resources, the homeless are also harder to place because of personal characteristics, a claim made by workers at Read.

To test this question, data on the BSI for those for whom living arrangements were made and those for whom they were not were compared. As is clear from Table 3.13, the group for whom no arrangements were made appear to be more symptomatic on average and also to have more intense symptoms. However, there were no statistically significant differences between the two groups. We can conclude then that while personality may have played a part in the likelihood of having arrangements made, in and of itself, it does not account for the difference between the groups.

It is also possible that there is some relationship between the likelihood of being told about outpatient treatment and having a plan for a place to live upon discharge. If in fact clients who were not referred in either situation were more "difficult" clients, then we would expect them to not be referred in both situations. Table 3.14 contains the results of this analysis and makes it clear that there is little relationship between the relevant variables. Thus, it would be difficult to conclude that people who did not have discharge plans were also people who were not referred for outpatient care.

Factors Related to Continued Outpatient Treatment. Of equal concern was a series of issues related to outpatient treatment. Since there is so much concern that decisions to end outpatient treatment when treatment is still needed may lead to homelessness, we wanted to examine the reasons

Table 3.13

Mean Scores on Selected Items from the BSI According to Whether Living Arrangements were Made for the Respondent Upon Discharge from the Hospital

SCALE	No Arrangements Made (40)	Arrangements Made (41)
PARANOIA	1.74	1.40
PSYCHOTICISM	1.06	1.01
HOSTILITY	1.23	.98
DEPRESSION	1.31	1.21
INTERPERSONAL SENSITIVITY	1.34	1.18
GSI	1.29	1.10
PST#	28.63	28.28
PSDI+	2.13	1.93

Numbers and percents are rounded.

#The number of respondents included in the analysis of this scale was 41 instead of 40 for the no arrangements made group.

+The number of respondents from the arrangements made group who were included in the analysis for this scale was 40.

Table 3.14

Outpatient Treatment Plans in Relation to Whether or Not Living Arrangements were Made at Discharge for All Hospitalized Respondents

TOLD ABOUT OUTPATIENT TREATMENT:

	Living Arrangements Made (41)	No Arrangements Made (37)
Yes	85.4%	74.2%
No	14.6%	25.8%

IF TOLD, RECEIVED OUTPATIENT TREATMENT:

	Living Arrangements Made (35)	No Arrangements Made (28)
Yes	76.7%	74.8%
No	23.3%	25.2%

IF RECEIVED, STILL RECEIVING TREATMENT:

	Living Arrangements Made (27)	No Arrangements Made (22)
Yes	51.6%	53.1%
No	48.4%	46.9%

Numbers and percents are rounded.

outpatient treatment was discontinued and the appropriateness of such decisions. Similarly, views of oneself as mentally ill or not mentally ill may influence treatment decisions and subsequently lead to homelessness. We wanted to see if this was the case among homeless respondents.

In sum, we found that the reasons most often given for terminating treatment among the homeless was their belief that they did not need it anymore. This was particularly so among those who were not homeless before their last hospitalization. However, when we compared data from the BSI in relation to outpatient treatment patterns, we found that respondents who were no longer receiving treatment were in fact less symptomatic on average than those who were still receiving it. Further, a comparison of those who were and were not still receiving treatment on the treatment cutoff point of the BSI also supported that the decision to stop treatment may have been an appropriate one. (See Tables A4 and A5 at the end of this report for these data.)

When we looked at perceptions of oneself as mentally ill in relation to outpatient treatment patterns, we found that there were no significant relationships between variables. Persons who thought they were mentally ill received treatment less often then those who did not. But regardless of their perceptions, the majority of respondents were more likely to be receiving treatment. Perceptions of oneself as mentally ill did not then seem to be a significant factor in treatment decisions and subsequent homelessness (see Table A6).

Mental Health Status of the Sample

The final area of exploration concerns the degree to which the non-hospitalized evinced a need for treatment. As noted at the beginning of the chapter, it is possible that many who need treatment are unable to receive it because they do not meet intake criteria which are, in turn, seen as being too stringent. Without institutionalization, necessary services may be unavailable and homelessness may be one result. As our measure of the need for treatment, we used the GSI cutoff point discussed previously.

In general, Table 3.15 suggests that as a group, the never hospitalized exhibit a good deal of symptomatology.[5] Almost one third of all never homeless and slightly less than one half of all homeless respondents scored within the the treatment-needed range. The difference between the two groups was statistically significant, implying that mental health problems are related to homelessness particularly among those who were never hospitalized. However, whether problems reflected in the GSI scores preceded homelessness or followed is difficult to say since we have only one score. A pre-homelessness measure for those who are currently homeless would have enabled us to better clarify the causal chain. It is possible that the lack of hospitalization for those who needed treatment may have resulted in homelessness. Yet analysis discussed earlier in this chapter indicated that hospitalization, in relation to mental health problems, has little impact on

---

[5] Compared to the hospitalized group however, never hospitalized respondents show less symptomatology regardless of whether they were homeless or not. On average, hospitalized respondents had higher scores on each of the individual scales of the BSI and on the global measures including the GSI. See Appendix Table A7 for these data.

Table 3.15

Proportion Above and Below the 90th Percentile on the GSI for Never Hospitalized Respondents: Never Versus Ever Homeless

	Total (439)	Never Homeless (164)	Ever Homeless (275)
Score is below the cutoff point indicating need for treatment	60.1%	67.7%	55.6%
Score indicates a need for treatment	39.9%	32.3%	44.4%**

Numbers and percents are rounded.

For ever homeless and never homeless comparison:

** $p < .01$

homelessness. Further, a surprisingly large proportion of the never homeless could also use treatment judging from their scores on the GSI.[6]

In order to get a better idea of the causal chain, we compared the never and currently homeless who had never been hospitalized. Table 3.16 presents this data and shows that the homeless group is still more likely to fall into the treatment needed category. However, in this instance, there are no significant differences between the never and currently homeless respondents.

Because the causal chain may be unduly influenced by the characteristics of the previously homeless, the relationships involved are more complicated than they appear to be. Nonetheless, these data once more suggest that mental illness is not the causal factor in homelessness. Nor do the data substantiate that homelessness "causes" mental illness. However, the currently homeless do show more of a need for treatment when compared to the never homeless, and while difference is not significant, it would appear that homelessness contributes to mental health problems even if it is not at the root of their development. Finally, given the high level of symptoma-

---

[6] Tables A8 and A9 at the end of this report also show the same breakdown of groups when the cutoff point for treatment was raised to the 98th percentile. We posited that because of the characteristics of our sample and their extreme poverty, they might score higher on the BSI as a rule, especially in comparison to the control group used by Derogatis and Spencer to derive the cut off criteria. Therefore, by raising the cutoff point, more people would fall into the normal range and the discriminatory capacity of the BSI given our sample's characteristics would be improved. As is clear from the data in these tables, more respondents did fall into the normal range. However, there is still a significant difference between the never and ever homeless groups. There is no difference between the never and currently homeless.

Table 3.16

Proportion Above and Below the 90th Percentile on the GSI for Never Hospitalized Respondents: Never Versus Currently Homeless

	Total (304)	Never Homeless (164)	Currently Homeless (140)
Score is below the cutoff point indicating need for treatment	65.0%	67.7%	61.6%
Score indicates a need for treatment	35.0%	32.3%	38.3%

Numbers and percents are rounded.

tology within the whole sample, especially among this never hospitalized group, it is clear that poverty may be taking a toll on the mental health of all respondents.

SUMMARY AND CONCLUSIONS

The data support certain impressions of the homeless mentally ill and fail to confirm others. Most striking is the fact that with the exception of their living situations, the homeless who have been hospitalized for a mental illness do not differ substantially from other hospitalized persons. The exceptions are that the homeless are significantly more likely to live alone in their current situation and they are more likely to be male. Nor do the hospitalized homeless differ greatly from other homeless individuals. Again, they are significantly more likely to have lived alone in the past and in their current living situations, but these are their only distinguishing traits. In essence, the hospitalized homeless are much like other homeless and they seem to be homeless for the same reasons as were noted in Chapter 2. It is likely that their needs are similar as well. Given that living alone tends to increase the likelihood of homelessness (as discussed in Chapter 2), and that those who have been hospitalized are more likely to live alone, we can posit that the relationship between hospitalization and homelessness is an indirect one in which living alone is the intervening variable. The fact that never homeless hospitalized persons as well as never hospitalized homeless respondents did not differ substantially from those homeless who had been hospitalized on variables such as income, work experience, or drinking behavior--variables which we would expect to be related to homelessness--lends greater support to this proposed relationship.

Second, with few exceptions, homelessness, at least initially, was not closely related in time to hospitalization. While there is some indication that hospitalization tended to precede the first spell of homelessness, it seems clear that homelessness in general did not commence immediately upon release. Given this time gap, it is difficult to conclude that homelessness was the result of "dumping." Further, the hospitalized homeless did not tend to have more hospitalizations, nor did their symptomatology differ significantly from that of other hospitalized persons.

It seems clear that the homeless were less likely to have living arrangements made for them upon release. Yet it was especially those homeless who were homeless before they entered a hospital who faced this situation. As noted, this may have been because they had fewer resources such as friends or family to whom they could be referred or because they had no homes to which they could be sent. Nonetheless, if there is anything which can be attributed to the mental health system with regard to its contribution to homelessness, it is that the system does not, in fact, end the cycle of homelessness. Helping people to obtain SSI, as Chapter 4 suggests, may make some difference. But to the extent that the attitudes about the homeless remain unchanged, the problem will remain, especially if workers believe that their efforts to help such people are futile.

Our informants within the mental health system as well as much of the literature on the mentally ill homeless emphasized that a stronger effort must be made to link those who are already homeless with residential programs. Similarly, the use of supported living environments is encouraged. Yet we have little information that many homeless were ever referred to either of these alternatives. Therefore, we do not know if such placements are limited or, if utilized, whether they might have an impact on homelessness. In addition, if such programs or supports are unavailable, it appears important to ensure that people who are referred back to their own homes or apartments are able to financially support themselves in such settings.

Despite the lack of referrals to living arrangements at discharge, the homeless were no less likely to be referred to outpatient treatment. Contrary to what informants reported, the homeless did get to treatment programs, at least initially, as much as the never homeless and they were also more likely to comply with medication regimens. Since there is some indication that the homeless may discontinue treatment over time, there may be a need for more programs like the Bridge or greater outreach efforts to look for those who have stopped treatment, especially after becoming homeless. Yet the data suggest that current outpatient programs may have little effect upon homelessness.

This situation may be related to the nature of the treatment which is available. As noted in the first section of this chapter, many of the intensive case management programs serving the chronically mentally ill in the community require five hospitalizations in the past three years as a service criteria. The majority of respondents in both groups had fewer than five hospitalizations. They may have, therefore, been ineligible for programs such as those discussed which address concrete needs as well as psychological ones.

The data from the BSI suggests that a large portion of the whole sample, including the never homeless who were never hospitalized, have symptomatology severe enough to warrant treatment of some kind. There was some indication that the homeless have more severe symptoms, especially when they had never been hospitalized. Analysis suggests that these symptoms were not necessarily a result of homelessness, but enduring traits. Yet there is also indication that homelessness may further contribute to existing mental health problems.

Sadly, we have no evidence that current treatment methods would help homelessness. As things now stand, it appears that hospitalization may only provide a temporary shelter. Logistic regression makes clear that hospitalization does not necessarily prevent homelessness when someone has mental health problems. Further, in light of the symptomatology of the entire sample, it is unlikely that mental health treatment, even if modified, would be the critical factor in preventing homelessness. The extent of sample's symptomatology suggests that it is the relationship between mental illness and poverty instead which bears closer investigation. Whether poverty is the causal factor in mental illness by itself or whether it compounds a biological predisposition or characterological trait, given the positive relationship between poverty and mental illness,[7] it is possible that addressing the sample's poverty will have a valuable impact on both mental health and homelessness.

---

[7] See Lorion and Felner, 1986, for a summary of the literature and some of the issues which are involved.

Chapter 4

Income Maintenance

One view of homelessness links the social problem to the nature of the public welfare system. The homeless, it is argued, generally cannot afford housing because they are very poor. Most of them would not be so poor if they received sufficient support from an income maintenance program. However, as in the case of mental health problems, this lack of sufficient benefits could reflect at least four issues.

First, while public welfare programs or other income maintenance programs are meant to provide an income floor, the possibility exists that this floor is too low. Because some welfare programs (e.g., AFDC and GA), have lost value in recent years, the resulting lack of cash might even be linked to the apparent growth in the inability to pay rent. The value of Aid to Families with Dependent Children (AFDC) benefits nationally, controlling for inflation but adding the market value of food stamps, decreased by about 23 percent over the course of the 1970s, and as this occurred, rent arrearages increased (Sosin, 1986).

A second issue may be rigidity that limits responsiveness to special needs. Over the course of the 1970s, most welfare programs made rules more definite and simple to verify, partly in response to federal pressure during the 1970s. The so-called "flat" grant, in which individuals with the same family size and structure, income, and work expenses receive the same benefits within a state, was developed. The problem is that a medical emergency may reduce monthly income; cash can be lost or stolen; an individual might need a special medical regimen; utility bills may consume too much income; or, given low benefit levels, the family may simply run out of cash in a given month. When the emergency strikes, under a flat grant no aid is given and eviction and homelessness may result.

Public emergency aid or special needs programs can, in theory, meet such special needs (as can private programs which will be discussed in Chapter 5), but the general pattern across the country is for few and limited specialized programs. Thus, in 1984 (the last year for which national data could be located) only 28 states had AFDC-Emergency Assistance programs (Social Security Bulletin, 1986). Emergency programs were even less common in General Assistance (GA), except in states in which the entire program meets emergencies, and not basic needs (Sosin, 1987). Emergency programs also tend to be quite small. The last known complete review of programs, as they stood in 1979, revealed that most programs focus on one or two situations within a narrow range of the population. The programs may be unable to respond with sufficient strength to help individuals avoid the loss of a home (Handler and Sosin, 1983). The typical program also has recently been reduced in size.

A third issue is access and thus the availability of any cash to pay rent. Lack of access may in part be a matter of restrictive rules. This is said to particularly be the case for Supplemental Security Income (SSI). Available to the disabled who cannot work (as well as to the poor elderly), SSI benefits are necessarily based on judgment of the extent to which a work-related illness occurs. Requirements might rule-out many individuals who indeed have problems obtaining a job, because these people, in theory, could obtain one. There is also the possibility that individuals cannot prove eligibility for AFDC, GA, or some other program in a system that allegedly requires increasing levels of verification to receive aid and to recertify eligibility later on (Brodkin and Lipsky, 1983; Piliavin et al., 1979; McDonald and Piliavin, 1984; Simon, 1983).

Finally, homelessness may also reflect the nature of those individuals who could, in theory, obtain income maintenance benefits. This relates to themes of alienation or pathology already described. That is, homeless individuals may be those who either do not believe that welfare benefits are worth the trouble, or who simply prefer independence. The homeless may also have specific emotional or mental problems that make it more difficult for them to apply for, or to continue to receive benefits. To what extent are these possibilities accurate?

CASE STUDY DATA

The case study material from Chicago can help suggest how the income maintenance system may (or may not) contribute to homelessness, particularly for the first three issues. We focus on four of the most central programs: Aid to Families with Dependent Children (AFDC), General Assistance (GA), Supplementary Security Income (SSI), and Aid to the Aged, Blind, and Disabled (P3).

AFDC in Illinois

Even though fewer of the homeless are in families than are single, the AFDC program in Illinois bears close examination. Its characteristics may have contributed something to the homeless experience of those 29 percent of the currently homeless in our sample who are members of families with children.

Benefit Level. Currently, Illinois has moderate benefits; the benefits per family ranked 26th in the nation in 1984 (the last year in which comparative data were available). In 1986, the last year in which Illinois data were available at the time of this writing, average benefits per family were only slightly greater than $300 per month. The payment standard for a family of three was $341 per month. According to Coalition for Family Stability estimates, total resources for a family of three on AFDC in 1986 averaged about $536 per month (adding the cash value of in-kind benefits); the poverty line was $705 per month.

Illinois has not hesitated to admit that these benefits are limited, and officials say that the low levels are a result of budgetary contingencies rather than of low client needs. Illinois thus has a well developed standard of need, and the grant met only about 50 percent of it as of 1986.

Indeed, over the course of the 1970s and 1980s Illinois's grant suffered larger losses to inflation than did the grant, nationwide. The Legal Assistance Bureau estimates that the Chicago area consumer price index rose by 95.5 percent between January of 1975 and July of 1983, while AFDC basic grants for a family of four increased only 15 percent over this period. Even taking the cash value of food stamps into account, the increase in AFDC was only 41.7 percent over the course of these years. Similarly, the Children's Defense Fund estimated that between July 1970 and January 1984, the Illinois maximum benefit increased 30 percent, so that when inflation was taken into account, the grant decreased in real terms by 49 percent. The decrease is so much greater than average that it may help explain why homelessness has apparently increased in Illinois and Chicago over and above its mid-1960s level.

Flexibility. Illinois has the classical flat grant system, to which it moved in the mid-1970s. In 1980, the state began to participate in the AFDC-EA (emergency assistance) program. The AFDC-EA program, however, is a bit two-edged; while the legislation seems to allow for support for a rather wide variety of needs, funding limits and administrative arrangements are such that the program tends to be quite limited in its ability to reduce the rate of homelessness.

This limit can best be seen on a simple accounting basis. As a proportion of its basic benefit package, the state's AFDC-emergency assistance budget is only $3 million a year in the most recent year in which numbers could be located (1985), compared to an AFDC budget of $900 million. In contrast, Massachusetts spends about 3 percent of its AFDC budget on emergency assistance. As of 1984 (the last year for which data were available), the average state program stood at about 1 percent of the AFDC budget.

In theory, the Illinois program covers all emergency needs. Thus, AFDC-EA is divided into two parts. One is the "special assistance" program, which is said to be available when homelessness is threatened due to a natural disaster, or perhaps due to eviction for reasons other than non-payment of rent. Also in existence is the "emergency assistance" program, which generally is available when eviction is threatened or when there is a lack of essential goods due to lost or stolen cash. However, to obtain emergency assistance, one must prove "uncontrollability," that is, that the need was beyond the control of the client. This is difficult to prove, and in the judgment of some workers, limits the aid to natural disasters. Further, those who receive housing with a relative or in a shelter apparently are not eligible because they are not officially homeless or threatened by it.

The limits placed on particular expenditures for both of these programs may not allow expenditures to rise to a point that a grant can help a family avoid homelessness. Thus the limit on rent is $142, which is lower than the average monthly rent of those who were homeless at the time the survey was undertaken (see Chapter 2). Charges for security deposits or rent deposits in excess of $142 are also not covered. Further, obtaining aid from the program demands special regional office approval, which appears to create a disincentive for workers to apply.

The hardship program, a third emergency program, covers many needs of those who do not qualify for AFDC. It might fill some gaps, but it is administered by a central (regional) unit and is apparently difficult to access. It also has similar limits on payment levels as those in place in the AFDC programs. For example, it has a $100 limit for a full bed, and a $150 limit for a refrigerator. Also, it can take as long as 45 days to dispense benefits.

Our interviews with local office workers and some legal aid workers indicated that the programs were not of dramatic utility in either avoiding or reversing homelessness. Some workers seemed relatively unfamiliar with the programs; the differences among the three were seldom apparent, and many workers could not think of an example of having used any program. One local office supervisor claimed that the training for the program was not sufficient and was all too brief, and that the need to submit certain requests to the central office was a disincentive to program use. In her office, only two or three such requests had been processed in about one year. She believed that some of the difficulties involved limited worker time compounded by difficulties with the forms. In particular, proving uncontrollability, proving eviction, and demonstrating the existence of the emergency in general were quite difficult to accomplish. Thus, those individuals or families who were evicted without a court order--the vast majority of the evicted homeless--are not eligible for these programs because they cannot prove the existence of an emergency loss of housing.

Access. In regard to access to the basic income maintenance program, little has changed since 1980. While some argue that the rules, in general, require strict verification of need and might limit access, there are few examples of unusually harsh requirements in Illinois compared to other states. We also saw little evidence that eligible individuals are turned away or discouraged from applying by workers' actions or other informal processes. State rules do not allow this; for example, they make it apparent that the homeless can apply. Few such turnaways make it to the legal aid office.

One possible exception is the multistep application process. An individual must wait for an interview at which screening occurs, must come back a second time to document need, and often must come back a third time to present the final documents. There also is a 23-day (on average) period between application and acceptance for AFDC. While not unusually long, the lack of benefits for pending cases might result in some destitute individuals becoming homeless.

Indeed, workers believe that verification, while not unusual, is strict and may result in homelessness for those who cannot meet the standard of proof. They believe that many of those who become homeless are those who do not have the needed records to prove birth, residence in the U.S., and so forth. But these proofs are necessary to obtain aid under the flat grant;

if they are not obtained, the state can be said to be in error in granting benefits to those who cannot prove their identity. The lack of birth certificates was seen to be particularly problematic to migrants, immigrants, or those who have lived in shelters for long periods of time.

Recertification. Advocates do not perceive any general problems with the periodic recertification process, but they do note some particular issues that might cause difficulty. Recertification requires response to a written notice, and individuals are cut-off of benefits if they do not respond. This is a general problem for those who move or have poor mail service; for the homeless, who may in theory have checks sent to shelters or other locations, the problem may be quite severe.

General Assistance

The state GA program, relevant for many of the homeless, varies across counties. In Chicago, however, it is administered through the public welfare (AFDC) offices, and aid is often granted by the same workers. In some ways, general procedures for the two programs merge, as do the potential problems.

Benefit Level and Form. The GA grant remained an as-needed program until 1982, with aid granted to maximums. While it is somewhat difficult to trace the exact generosity of the program (because it depends upon an estimate of other sources of income that individuals may have), many believe that a typical grant for those who did not work and received the maximum rent allowance might have been $198 per month (in 1981); for those living in rooms without cooking facilities, the grant might have reached the mid two hundred dollars.

The state administration moved to a flat grant system in the 1980s. After much political wrangling, the grant was set at $154 per month for one individual. Later it was decreased to $145; it was adjusted once in 1985 to $154 per month, and was at this level at the time of the survey. Clearly, this represents a net decrease since 1982 for many individuals. In fact, the flat grant was meant to save about 6 or 7 percent of the total GA budget in 1982, which perhaps is one measure of the nature of the typical cut in the grant, not including the effects of inflation. The Illinois Campaign for Family Stability calculates the typical total budget for an individual receiving GA (or AFDC, which has the same grant size) at $244 a month including food stamps and the federal energy payment; the 1985 poverty line for one person was $438. It is even conceivable that homelessness can occur because the grant is not at all sufficient to meet basic needs. We should note, however, that while the AFDC program is quite a bit lower in grant level than that of some midwestern states, the GA grant is closer to equivalent: one might suggest that many of the potential problems the single, childless, or non-disabled adult faces in Chicago are common.

On the other hand, GA is somewhat generous in its income disregard for those who work. It has a $75 a month disregard, plus the difference between the standard of need and the actual grant. This also can contribute to the well-being of those who otherwise might be homeless. GA also seems to allow for even greater doubling up with relatives or friends than AFDC with no loss of benefits. This is said to be very important in avoiding homelessness for some. Many believe that the homeless double up to get out of homelessness and that, given rent levels in Chicago, GA recipients can only survive by a combination of help from family and friends, doubling up and also possibly free meals from soup kitchens.

Special Need Procedures. Administratively, the GA program is quite different in the lack of an emergency assistance or special needs program. As a completely "flat" grant, it does not enable workers to meet special needs that may arise. For this reason, there have been a number of attempts to legislate additional expenditures in GA for emergency grants. None have succeeded as yet, so that single individuals with special needs cannot rely on the program to provide cash that may avoid homelessness.

Access. General requirements for eligibility and for recertification for GA do not demonstrate divergence from those in the AFDC program. For example, the offices delivering services are the same, so that the same type of intake process prevails. The three-stage application phase may be a problem in both cases; few believe that there are systematic efforts to dissuade anyone from applying at this point.

However, one distinct verification issue stands out as a problem according to workers and legal aid attorneys--that of proving "past management." For whatever reason--some believe that the reason may be an attempt to ensure that those who apply actually need aid--individuals must prove how they were getting along previously, and thus why they need GA now. Some believe that this is a "big factor" in decisions, a "major question" which may cause difficulties and lead some to become homeless because they cannot obtain benefits. One problem is that one needs a note from friends or others who might have helped meet financial needs in the past, and that this is so demeaning that some are alleged to drop out at this point or to be unable to produce the documents.

The Special Issue of Job Programs

Illinois has an unusually high interest in work and work training in welfare. At the time in which these data were collected, most GA recipients were expected to enroll in "GA JOBS," while the work program for AFDC, the Work Incentive Program (WIN), was also being run as a mandatory program in Chicago. Since that time, the programs have been replaced with Project Chance, but we believe that the relevant rules remain similar.

This emphasis on jobs was another product of the early 1980s. The GA JOBS program and mandatory WIN participation were instituted as a result of 1979 legislation, piloted in 1981. This law required all recipients of public assistance, except those specifically exempted by the Illinois Department of Public Aid, to participate in job search, training, and work programs. At the start of the programs in 1981, approximately 80 percent of GA recipients were deemed employable and thus were expected to be mandatory participants. By 1983, all GA recipients were called in for a work readiness interview. The requirements seemed to become firm for AFDC recipients in about 1985.

Under the new program, Project Chance, individuals who do not have a particular exemption are expected to participate. This involves attending a meeting to establish program enrollment, further meeting attendance, and cooperation with a job training or work search program. Components of the program include intensive job search, pre-employment, a job club, work experience, a special project, or a modified work search.

For those in one of the components requiring a search for a job, individuals must complete and provide verification of twenty acceptable employer contacts every thirty days. For meetings of this, and any other component, participation is mandatory, and unexcused absences may result in suspension or eventually termination from the program. Disqualification generally occurs for a failure to appear for the assessment interview without good cause; a sanction occurs for mandatory registrants who miss a meeting or do not fulfill other program expectations. The sanction period is three months for the first problem and six months for the second.

Generally, two unexcused absences in a 60 day period cause a sanction to be imposed. The long list of possibilities for sanction include failure to respond to an interview, to verify the employer contacts, to accept any offered testing or employment counseling service; any disruptive activity; or missing a day of a work assignment. (Most of these rules hold in the GA JOBS program, in which the same level of sanctions are used but somewhat fewer employer contacts are expected.) It should be noted, however, that even though clients do not know this, advocates claim that an exact number of job interviews may not be required in practice as long as an individual appears to have looked for a job.

While we cannot verify the opinions completely, workers and legal aid employees expressed considerable concern over jobs programs. They suggested the possibility that sanctions for non-cooperation could be applied too often, and that the resulting lack of a grant could lead to homelessness. Some income maintenance workers generally had a very negative attitude about how rules were applied saying that they had "little positive" to say about WIN and GA JOBS workers, that the workers are those who did not have sympathy for clients, and that they demand many appointments but generally do not find jobs for clients.

Legal aid advocates note problems with the excused absence requirements. For example, before a recent court case, individuals who came five minutes late could, and at times were, suspended for two months--even though they were allowed to complete the meeting and were only later told of their suspension. Some believe that the new court decision implies that AFDC recipients can only be suspended if they do not go to a job. If they miss a meeting, they are not suspended. But a continuing major problem remains for GA. Also of concern is that some individuals do not receive notices of meetings--mail service is alleged to be notoriously inadequate in poor communities with multiple, confusing mail boxes. Those who do not get mail and miss appointments have their benefits discontinued.

Some officials believe the jobs individuals receive are satisfactory, while some had more questions. But it is interesting that national data from which Illinois can be compared to other states paints a rather bleak picture of the issue. This data comes from objective, outside reviews of job programs for AFDC recipients in Illinois and elsewhere. Many programs had the same structure, that is, meetings and requirements to search for work. Workfare is used if clients do not find a job. But while most programs were quite small, Illinois had a large one. As the preliminary reports indicate, there is some evidence that the Illinois' programs had less time for individualization. Perhaps as a result, Illinois' programs seem to have the highest number of disappointed AFDC work program participants. These participants are also most likely to report that the employer gets more out of the job than does the employee. For example, in the San Diego experiment, nearly all clients in jobs claimed that they liked their work, and slightly over one half of those surveyed claimed that they received as good of a deal out of the programs as did the employer. The vast majority claimed that the program was fair (Goldman et al., 1985). In Illinois, however, 56 percent of those surveyed said that they were dissatisfied with getting benefits through this program, while 82 percent claimed that the employer obtained a better deal than the employee. The authors note that the Chicago program was the only one studied for which the majority of the respondents seemed to have a negative attitude toward the program (Quint and Guy, 1986). This might result in a failure to cooperate and thus sanctions.

Evidence about discontinuation in the program due to sanctions confirms this. In San Diego, for example, 5 to 6 percent of all of those enrolled (this varies slightly across different types of programs used) were discontinued due to sanctions over six months. In Chicago, the figure was somewhere around 8 percent in three months. Assuming that rates are constant over time, the Chicago rate is about three times as high as the San Diego rate.

There is other evidence that, at least historically, there are important problems with sanctions in GA work programs. According to the Public Welfare Coalition, in FY 1985, 52,019 individual were cited for non-cooperation statewide. Over 40,000 of these were GA recipients. The total for all programs decreased slightly to 43,402 in FY 1986, and included slightly under 35,000 GA recipients. Sanctions were double the number of claimed job placements. Similarly, data on a cohort of GA recipients collected by Stagner and Richman (1985) suggest that a large proportion of a studied GA cohort lost benefits for non-cooperation. At a follow-up of individuals who had just obtained GA benefits six months before, 76 out of a sample of four hundred reported that they were "cut off" from GA; 18 others were "cut off" but had again obtained benefits by the time of the follow-up interview. Thus, nearly one-quarter of the sample reports a cut off in the six month period. According to state records, ninety one of these individuals were cut off for non-cooperation and did not receive benefits at the time of the second interview. To be sure, some of these may actually have failed to cooperate because they already obtained a full time job. But only 43 percent of such respondents had a full or part time job by the time of the second interview. As we shall see, there is evidence linking work program discontinuations to homelessness, but only for such GA recipients.

Supplementary Security Income

Some proportion of the homeless are disabled. A moderate proportion have been institutionalized in a mental hospital, and many of these may be mentally disabled; a few may be physically disabled. Individuals who meet at least certain standards of disability may be eligible for SSI (along with those elderly who are not eligible for Social Security benefits). For the mentally ill, in particular, it is alleged that the application procedures or inability of individuals to utilize them have much to do with homelessness.

Benefit Level and Form. There is good reason to believe that the reception of these benefits will help many avoid homelessness. These benefits have been matched to inflation since their inception in 1974. The levels, $332 a month for an individual in 1986, for example, are higher than any other available benefits in Illinois' income maintenance system. Thus, they are nearly double the level of benefits available through GA, enabling many individuals to avoid homelessness.

If the trend in access to the program is compared to the trend in homelessness, one might be wary of ascribing any increase in the lack of a home to the benefit programs. In Illinois, it is clear that the proportion of individuals receiving SSI has increased over the years. In February of 1974, for example, the cases of the aged totalled 47,350, and aid to them cost $3.2 million; the figures for the disabled were 82,591 cases and $9.67 million (omitting the blind). With growing Social Security coverage, ten years later the figures for the elderly stood at 31,157 cases and $4.6 million; but the figures for the disabled rose to 94,046 and a rather large $22.3 million (Social Security Bulletin, 1976, 1986).

To be sure, one can argue that the nature of the program is such that it does not always help individuals to avoid homelessness. For example, the Illinois program does not have anything like AFDC-Emergency Assistance; it might be that homelessness occurs among individuals who experience a crisis and have a special need. Others insist that even these benefits are so low as to make a lack of cash lead to eviction. Nevertheless, access seems to be the core issue.

Access. Since its inception in 1975, SSI has gone to great lengths to insure consistent decision-making about disability. However, this is very difficult to achieve. Medical diagnoses are subject to disagreement among physicians, and often depend on the subjective reporting of recipients. Some believe that recipients will exaggerate conditions to obtain benefits. Others argue that some individuals with serious conditions will continue to search for work and will thereby forgo benefits. And, while written standards exist, they tend to be couched in terms that leave some room for discretion.

In SSI, the disability decision is not always made by the federal government and is often contracted. In Illinois, the Department of Rehabilitative Services determines if the eligibility standard is met and recommends a payment decision. The agency works primarily on the basis of a review of records supplied through the application process by physicians, the applicant, and others. If an applicant disagrees with the decision, an appeal process occurs. This can eventually culminate in a hearing before an administrative judge.

If an individual obtains benefits, regular reviews will be held. These reviews vary, depending on whether or not the individual, who must be disabled for 12 months to be eligible for either the workers or non-workers segment, is deemed to be permanently disabled. Reviews can occur at one, three, or five to seven year intervals.

As is well known, the standards have been the subject of much controversy. They have changed in ways that might have implications for access to benefits. Thus, there was a general increase in applications and acceptances until the early 1980s. However, at this time it appears that federal pressure was brought to bear to reduce access. There is evidence, for example, that in the early 1980s the federal government brought pressure on administrative judges who hear appeals to reduce their appeal rates (the rates generally are at the 50 percent level). The reviews of cases between 1981 and 1983 were quite controversial. Illinois data could not be located, but nationally, 946,000 cases were reviewed, with about 421,000 terminations; upon appeal about half of the terminations were reinstated. There is a widespread belief that those with mental health problems were over represented among those who were cut off, and that many became homeless.

Questions arose about the validity of these terminations. Studies indicate that small proportions of those terminated worked afterwards, making many wonder whether the terminations occurred among individuals who had the potential to work. For these and other reasons, in 1984 congressional pressure lead to a temporary halt to the reviews. In addition, legal pressure caused the 1981 period cut-offs in Illinois to be reconsidered, with individuals restored to the benefit rolls until new rules could be instituted. Since that time, federal and state decisions have been such as to increase access, particulary for the homeless and mentally ill.

New Rules. One response to criticism and to special concerns about the homeless involved what appears to be increased access. The new rules could conceivably reduce problems that can cause homelessness. The 1985 regulations thus mandate that state offices will, if asked, provide outreach to shelters and to many other types of services that the homeless use. The regulations also provide that a district coordinator be provided for access services, that correspondence be sent to a third party if a homeless applicant or recipient so demands, and that the homeless be allowed to receive their checks at mailing addresses such as those provided by shelters and drop-in services.

National guidelines also call for the existence of a referral service for those who might need benefits. In Illinois, the referral service is called the Applicant Assistance Unit. It works through a telephone hotline in Springfield. It is administered out of the state disability office. In 1985, it received 5,953 calls. In addition, SSI adjudicators made 667 calls. Responsibilities vary from providing crisis services, such as transportation or even lodging, to acting as an advocate with the Social

Security Administration or the Department of Public Aid, utility companies, or administrative law judges. The unit also answers questions about the program and keeps a list of possible referral sources for services. The number of calls, of course, is not particularly high for a statewide service, but it certainly indicates that the unit helps some of those with special problems.

New Standards. Another set of changes apparently increases the availability of benefits through the eligibility criteria. One change is a recent court case that limited the use of a view of impairment that did not take multiple problems into account. Recently, the standards for mental illness have, in theory, also become more lenient. The mental health categories now include anxiety, affective disorders, somatoform disorders, and personality disorders. Substance addiction is covered, but only if it leads to such covered impairments as depression, organic mental disorders, or seizures. Understanding that impairments might not be apparent from a single encounter, evidence now includes past work experience and history of mental problems as well as functioning at the time of the interview. This clearly should increase the coverage. At the same time, the specific standards for anxiety disorders and many of the other listed categories can increase coverage.

Other changes occur at redeterminations, in which proof either of medical improvement, or of new technologies to help individuals improve, or advances in rehabilitation affect certifications. Generally, two of the standards must be met, or three in the case of somatoform disorders and personality disorders. Nevertheless, the criteria are clearly less stringent than previous ones.

There also have been efforts to improve the process. For example, in Illinois, the Department of Public Aid now pays for psychological evaluations for the SSI process. Advocates believe that the Disability Adjudication Service is now carrying out "better evaluations."

Finally, the number of redetermination hearings has been reduced since the early 1980s. There was a federally mandated moratorium on the hearings, followed by the application of new rules that appeared to change the burden of proof. Generally a change in work capability needs to be demonstrated before one can be eased off the program.

System Complaints. Despite such changes, client advocates believe that the SSI system remains a difficult one. Rejections that might lead to a lack of cash and thus homelessness--whether by workers, or an appeal to workers, or even at the second appeal to an administrative judge--are said to be common. Advocates claim that a few workers will ask individuals if they are willing to work; this is a trick question, because a "yes" answer is said to imply an ability to work. In addition, many who do not quite meet the theoretical inability to work actually will never be hired, given unusual personalities, affect, and so forth. Finally, refusal of treatment can result in denial of a determination, although paranoid individuals or alcoholics, in particular, might refuse as part of their specific problems.

It is also claimed that those who are successful in achieving benefits often are those who can make it through the appeal process. Some legal aid workers go so far as to imply that denials for the first visit are routine, and that it is "unusual" for someone to be accepted without an attorney. There is a general view that the "squeaky wheel gets the grease" in the SSI system.

The issue of time may also important. Legal aid workers believe that the cases they deal with generally take about 9 months to resolve. In addition, many of those with mental impairments may make mistakes in the process that result in even longer delays. For example, a mentally ill individual may decide to go to a hearing, alone and without evidence; if there is a denial, the case needs to begin again. Homelessness may occur over the course of the long waiting period.

The mentally ill are said to be notoriously inept in making use of welfare programs. It is alleged that the very act of waiting to apply at an office, perhaps for hours, is beyond the capabilities of many. For those with paranoid fantasies, the detailed questions asked by workers might be overwhelming. Those who work in shelters occasionally claim that only about half of the mentally ill who are referred can complete the process. In addition, some legal aid workers feel that, when an SSI office gets overloaded, it will ask individuals to come back another day. Many will not.

Workers claim that to receive SSI, a mentally ill person has to be nonfunctional. Advocates are concerned that there are many who have personality problems, delusions, or personal styles that completely interfere with obtaining a job, but who do not obtain SSI benefits. The claim is that the examinations underplay certain mental disorders, that the inability to get along with others is not very seriously considered. It is claimed that the procedure of taking into account education and the community, looking at possible jobs an individual can do, and whether or not the jobs exist, results in a lack of access and thus perhaps homelessness.

Mental Institutions and Benefits. One particular problem is the relation of mental health institutions to SSI. Given the problem with alleged "dumping," the institutions have tried to strengthen their attempt to plan for disabled individuals before they are released. As we have seen, for those who are sent to the community, every attempt is made to find a place for the individual to stay, in theory--although on occasion this may be a shelter. To provide cash for those who will remain independent, the agency attempts to help individuals obtain SSI.

One issue in favor of the institutions is that the average length of stay in Chicago is said to be 14 days; and, state laws and federal laws provide that SSI eligibility be continued if the individual is in an institution for less than a month. For the equally common case in which there is no existing benefit, workers may fill out forms before release, using a designation that results in more quick service from SSI. However, the process still takes about 14 to 21 days, so that the individual may be released before a decision is reached or new information is requested.

The rule that workers in mental health institutions must help clients apply for benefits is not a new concept; it has existed since 1978. For unknown reasons, however, workers apparently seldom complied. When they now comply, we were told, they often fill out forms in ways that are not particularly helpful--they may forget to sign a form, for example, or may talk of the "strengths" and "weaknesses" of a client in a manner that makes a decision about work ability difficult, because the subject is not directly broached. This problem is likely to be as much a result of institutional priorities and training as anything else; few workers in mental health institutions are trained from a perspective that relates to the need for material assistance, for example. But the State Department of Mental Health, along with the Illinois Department of Rehabilitation, has been conducting seminars in the institutions around the state to help improve competence.

Pending Cases

Finally, Illinois has a special program for those who are pending SSI--Aid to the Blind, Disabled, or Aged, or the "P3" program, as it is commonly called. In 1984, the program became readily available for individuals who are applying for SSI but who are not yet eligible, and it clearly is intended to be a very important instrument in helping to fill the gap made by the long delays in SSI.

Eligibility for P3 is relatively straightforward; an individual simply must prove that he or she has applied for SSI by obtaining documentation from the SSI office. Legal aid workers worry that the need to travel back and forth between offices might limit the use of P3, particularly when a GA applicant is ordered to apply for SSI, and then has to come back to prove P3 eligibility. In addition, with an estimated 30 or 60 day waiting period for P3, individuals may be without benefits for a considerable period.

Outside of this, however, few complaints about the program were mentioned in our interviews. In theory, an individual who is denied SSI eligibility can again apply and receive P3 for 60 days, and can repeat this process continually, obtaining P3 for longer periods, at once, if they were not yet denied.

The main disadvantage of P3 is its absolute value. While the payment standard is somewhat higher than that of GA, at $191, this is only obtained if the individual is paying at least $125 a month for rent. When individuals live with others and pay less rent, they receive less benefits. This probably accounts for the fact that GA grants actually are somewhat higher than P3 grants for the majority of cases. Perhaps the most important problems are for the homeless, who do not receive any housing allowance because they have no housing. Their total benefits under the program are well under $100 per month; many avoid the program.

In addition, certain advocacy measures are attached to P3 as continuance benefits costs the county money. When an appeal is successful, back payments must be given for the amount of SSI that would have been received. This reimburses the state for its P3 contribution and dispenses some extra cash to the recipient as well. However, 25 percent of the savings is given to an attorney who successfully appeals. The legal aid attorneys, in particular, felt that this creates enough of an incentive so that no further incentive is needed for the appeal process.

STATISTICAL RESULTS

The statistical data from the survey can further specify some aspects of the relation between income maintenance programs and homelessness suggested by the overview and the case study. Issues of the lack of willingness to accept benefits or a lack of access are particularly amenable to analysis.

Life Time Access to Benefits

Some claim that welfare rules are not related to homelessness because many members of the population have shown no interest in using programs over their life. To begin to assess the issues surrounding life time use of benefits, Table 4.1 reports answers to a question concerning whether individuals ever had experience with an income maintenance program as an adult.

If the criteria is life-time receipt of assistance, homelessness does not seem to be caused by a reduced propensity to make use of benefit programs. Table 4.1 notes that approximately 85 percent of those who have ever been homeless have applied for, or received, some income maintenance benefits over the course of their lives. The corresponding figure for those who have never been homeless is 72 percent; the difference is statistically significant. If anything, then, the homeless are more likely to have applied for benefits.

Among the currently homeless, roughly 79 percent have ever applied for benefits, while 82 percent of those who are not currently homeless have applied. This difference is not statistically significant. By either comparison, then, there is no evidence that, among the very poor, the homeless are less likely to be aware, or to be ready to use, benefit programs.

Nevertheless, it must be stressed that roughly 20 percent of the entire sample never applied for welfare. While this lack of application does not relate to homelessness in any special way, for a few individuals it can be a general contributor to being very poor, and thus perhaps to becoming homeless.

Welfare Attitudes. Some individuals may fail to apply due to negative attitudes or other problems. To begin to assess if this is the case, Table 4.2 presents responses to a small series of questions about attitudes to "welfare," as it was called. Three of the questions involve attitudes toward specific interactions with welfare. In each case, a fair proportion of the respondents have a somewhat negative attitude. Fully 43 percent of

Table 4.1

Income Maintenance Experience

	Proportion with:		
	Any Maintenance Program Experience	No Experience	Reporting Cases
Total Sample	80.6	19.4	531
Life-time Homelessness:**			
Never homeless	72.3	27.7	182
Ever homeless	85.0	15.0	349
Current Homelessness:			
Not homeless	81.7	18.3	353
Homeless	78.5	21.5	178

** $p < .01$ for the two group comparison.

Note: Numbers and percents are rounded.

Table 4.2

Attitudes Toward Welfare

	Percent Agreeing (of Respondents)	Number Responding	Number Who Don't Know
System Defects			
Cannot get to welfare office easily	34.3	518	9
Too hard to fill out forms for welfare	22.8	512	15
Welfare workers hassle too much	43.0	504	20
General Attitudes			
Does not need welfare	19.2	522	4
Does not believe there should be welfare	11.3	519	8
Does not deserve welfare	17.0	517	9
It is embarrassing to receive help from welfare	27.4	518	9

Note: Numbers and percents are rounded.

the respondents claim that welfare workers "hassle" them too much; 34 percent believe that it is difficult to get to welfare offices; but only 23 percent believe that it is too hard to fill out forms for welfare.

The last four items listed refer to general attitudes about welfare programs. In this case, attitudes are not particularly negative. Twenty seven percent of the respondents claim that it is embarrassing to receive help from welfare, while only 11 percent claim that there should not be welfare. Less than 20 percent believe that they do not deserve or do not need welfare.

To determine whether attitudes predict the propensity to apply to welfare, the various measures of attitudes were cross-tabulated against the measure of ever applying for welfare. In addition, multivariate analysis was completed. This was accomplished through a "logistic regression," whose results are not presented on a table.

By the simple analysis, there were two statistically significant determinants of never applying for welfare. One was the item concerning the belief that the individual does not need welfare. Thus, about 33 percent of those who have never applied say that they do not need welfare; 16 percent of all others give this response. The second is the perception that the individual does not "deserve" welfare; 14 percent of those who have applied, and 28 percent of those who have not, give this opinion. However, when the regression is analyzed, the variable concerning "deserving" welfare no longer demonstrates a statistically significant relation to having ever applied to welfare. Apparently some of those who do not believe that they deserve welfare are actually implying that they have no need for it, and thus do not deserve it.

It is no surprise that those who do not believe that they need welfare apply for it less often. Yet only a minority of those who have never applied for any welfare program espouse this attitude. Interestingly, other attitudes did not predict application: not those involving perceptions of welfare stigma, perceptions that workers hassle them, perceptions that the office is too far away, perceptions that it is difficult to apply for welfare, and so forth. Except for the perception that the individual does not need welfare, there is no evidence that the very poor are deterred from applying by specific attitudes--even though an uncomfortably high proportion are not happy with the program.

Other Causes for Never Applying. Table 4.3 examines, in bivariate form, relations between other individual variables and having never applied for benefits. One argument might be that those with more "pathologies" in the sense of a history of a placement in a mental hospital or heavy alcohol consumption are less likely to have ever applied. However, those with experience in a mental hospital are more likely to have received benefits, not less likely. Those who are binge drinkers (one measure of alcohol consumption) demonstrate a similar, although not quite statistically significant, relation in this direction.

Another claim might be that those who are alienated from institutions due to negative experiences in the past might be less likely to apply. The evidence on attitudes does not confirm this. Further, on two indirect measures of alienation, that of out-of-home placement as a child, and military service, no such relation is found. Others might argue that a history of work might preclude application, but there is no difference between those who have applied and those who have not on measures of the percent of time

Table 4.3

Relation of Various Measures to Ever or Never Having Experience with Income Maintenance Programs

	Any Maintenance Program Experience	No Program Experience	Reporting Cases
Percent Male	67.2	82.5**	530
Percent Black	72.4	56.6**	526
Average Age	37.4	37.2	525
Years of Education	11.1	10.5*	526
Percent Binge Drinker	19.4	11.6	525
Percent Ever in a Mental Hospital	18.2	7.3**	524
Percent in Childhood Out of Home Placement	12.5	9.0	529
Percent Who Had Been in the Military	22.0	25.6	530
Percent of Time Worked since Adulthood	51.5	54.3	529
Days Since Left Last Job	336	315	449
Days Since Came to Chicago	2218	1579	521

* $p < .05$
** $p < .01$

Note: Numbers and percents are rounded.

worked since becoming an adult nor the time since having the last job. Age and length of residence in Chicago also demonstrate no relation.

The statistically significant relations are that those who have never applied are more likely to be male, and less likely to be black. They are also somewhat less educated. This last relation may indicate that those with less knowledge or ability about how to apply are less likely to receive welfare. The relation involving sex might suggest that GA is either less accessible or more easily avoided; most of the men do not have custody of children. No obvious explanation for the relation involving race could be found.

Otherwise, putting together information on attitudes with the above cross-tabulations, the relations merely suggest that those who believe that they do not need welfare are less likely to have ever applied for a program. Those who have more pathologies may have more program experience either because they came into contact with agencies that advocate for them or because they are least able to cope without benefits. But in general, the lack of ever applying apparently is not the major cause of homelessness for any group, nor are particular individual motivations very important to this problem.

Current Receipt

If most individuals once received benefits, attention turns to their current use and how this relates to homelessness. Table 4.4 presents evidence on the current receipt of income maintenance benefits, separated by whether or not the individual was currently homeless. Looking at the overall percentages first, it is no surprise that the most typically received

Table 4.4

Current Receipt of Welfare as a Proportion of All Respondents

	Percent of		
	All (n=530)	Those not Currently Homeless (n=353)	Those Currently Homeless (n=177)
Program			
AFDC	14.2	10.9	20.6**
GA	34.3	42.6	17.6**
SSI	7.4	9.7	2.7**
Social Security	4.3	5.7	1.4*
Veteran's Benefits	1.5	2.3	0.0*
Aid to the Aged, Blind, Disabled	1.4	1.5	1.2
Unemployment Benefits	2.2	2.4	1.8
Emergency Assistance	2.2	2.1	2.4
Energy Assistance	2.6	3.9	0.0*
Other Public Program	1.1	0.0	1.4

* $p < .05$
** $p < .01$

Note: Numbers and percents are rounded.

benefits stem from GA, with 34 percent of the sample receiving this type of aid. For AFDC, the figure is 14 percent of the sample. It is natural that AFDC benefits are less common in this sample, because only about 26.9 percent of the sample consists of individuals who have custody of children. SSI benefits are received by about 7 percent of the sample, while 4.3 percent receive Social Security benefits. Rather small percents receive benefits from any other program.

Parenthetically, it should be noted that, among those over age 65, only 5.0 percent receive SSI and only 35.8 percent receive Social Security benefits. Even adding these together, only a minority of those who are in theory eligible for such benefits receive them. This might explain why these elderly individuals are included in our sample of the very poor.

Differential access can be gauged by comparing benefit receipt of the currently homeless with that of the domiciled. Large differences suggest that access is a key problem; similarities suggest that grant size is most important. Overall, it is clear from Table 4.4 that a lack of benefits is associated with being homeless, at present. Looking at receipt of any income maintenance benefits, roughly 45 percent of the currently homeless receive welfare, while 67 percent of those who have a place to stay receive benefits. This difference is statistically significant.

Receipt of many types of benefits varies greatly by group. It is perhaps surprising that twice as high a percent of those who are homeless receive AFDC benefits compared to those who are not; this difference is statistically significant. To be sure, at least at first glance, those who are homeless are more likely to be in a family unit that is potentially eligible for AFDC. That is, 29 percent of the homeless are in family units that involve children; this is true for 23.5 percent of those who are not homeless. While it is only a rough estimate, however, the proportion of those who are potentially eligible (due to family structure) for benefits who receive them also varies by group. About 69 percent of currently homeless individuals whose households include children receive benefits; this is true for only 47 percent of those who are domiciled. This difference probably occurs because the transitional shelters at which many of the homeless families are located help individuals apply for welfare. As we will note later on, many of these families probably obtained benefits recently after a period in which they did not have benefits.

The underrepresentation of beneficiaries among the homeless is statistically significant for the following listed categories of benefits: General Assistance, Supplementary Security Income, Social Security, and Veteran's Benefits. The most striking differences involve General Assistance. In this instance, about 43 percent of those who have places to stay receive benefits, but this is true for only about 18 percent of those who are homeless.

It is true that some individuals are not eligible for GA benefits. But the differences uncovered cannot easily be attributed to this factor. Those who are potentially eligible include sample members who are not members of families with children and do not receive any other types of benefits. This includes 56.4 percent of those who are not homeless, and 64.2 percent of those who are homeless. By this admittedly rough standard, 75.5 percent of the potentially eligible who are not homeless receive GA, but only 27.4

percent of the potentially eligible individuals who are homeless receive such benefits.

The differential in the receipt of SSI benefits is also large, with almost 10 percent of those who have a home, but only about 3 percent of the homeless, receiving benefits. To be sure, some benefits can go to the elderly, and a larger proportion of the non-homeless are elderly (see Chapter 2). Among the elderly, however, only one individual receives SSI (out of the sixteen reporting individuals); this individual is not one of the two homeless individuals who are over aged 65. As a proportion of the non-elderly who are not homeless, 9.9 percent receive SSI; among the homeless, the percent is only 2.8.

Even though we cannot measure eligibility for SSI directly, the above results suggest that the homeless might be much less likely to obtain benefits, when eligible. One rough way of confirming this is to examine benefits among those who have ever been in a mental hospital. Presumably, a large share of these individuals are eligible for SSI benefits.

Among all who have been hospitalized, 19.8 percent receive SSI benefits. This is a small percent, but a much smaller 4.9 percent of those who have not been hospitalized receive benefits (the difference is statistically significant). However, among those who are homeless at present, and who have been in a mental hospital, only 2.3 percent receive SSI; the statistic is 35.0 percent for those who are not homeless. Thus those who are homeless, even when having a pattern of institutionalization, are less likely to receive SSI benefits.

Clearly, SSI benefits are great enough to keep many individuals who have them from being homeless. This accounts for the difference in the proportion of the homeless and non-homeless with such benefits. But why is it that the homeless who are mentally ill are less likely to obtain them?

One possibility is that the homeless are often in situations in which obtaining benefits is more difficult. In theory, individuals can apply for benefits directly upon release from a mental hospital. But it might be that those who had no place to go upon release were less able to follow through on this process. While there are too few cases to look at separate analyses for those who are now homeless and those who are not, in general, 16.4 percent of those who had no arrangements made receive SSI; this is not much different than the percent of all of those with mental health facility experience who responded to the question who receive SSI, 19.2 percent. The tendency for those who had no plans to also fail to attain SSI benefits is thus small (the difference is not statistically significant).

Similarly, while one might expect more difficulties in obtaining SSI for those who had already been homeless before they had any mental institution experience and thus may have a less stable residence, 14.3 percent of these individuals receive SSI. The figure is 19.2 percent for respondents who either were not homeless or were hospitalized before becoming homeless. The difference is not statistically significant. While not definitive, this again reveals no evidence that those for whom planning was more difficult are less likely to receive SSI. Indeed, of those who had not been homeless at the time of their entire history of institutionalization, only 5.4 percent are receiving SSI; there is no evidence that SSI benefits are achieved more easily by those who are most likely to have had a stable residence at the time of institutionalization.

These results cannot tie down all the loose ends, but they in part confirm the existence of certain problems with SSI. Yet, as we will see later, very few individuals had been turned down from SSI programs within the last six months, and few have been recently discontinued. We cannot confirm alleged problems with refusals to grant aid to applicants (with a few exceptions, to be noted later). One might guess that, if problems of acceptances or cut offs still affect the homeless, they might partly stem from individuals who had particular problems in the more distant past.

More problematic might be the failure of individuals to apply and perhaps the failure of others to assist in the process--failure that might come from negative experiences. Indeed, the results suggest that those with more experience with mental health services are not more likely to receive benefits; perhaps many clinics and programs in the community are not very helpful in this respect. It is conceivable that, all other factors being equal, those who are homeless are those who have had less help in applying for SSI benefits from the mental hospital and from outpatient services.

Another issue is the relation of alcoholism to receipt of benefits. It has already been noted that alcoholism per se is not an eligibility criteria, but alcohol related problems might make SSI more likely to be obtained. Among those who are not currently homeless, 17.2 percent claim to be "binge" drinkers. Of these, about 12.4 percent receive SSI; only slightly higher than the proportion of all of the not currently homeless group. This confirms the claim that alcoholism is not an automatic criteria for obtaining these benefits. However, among the currently homeless, 18.4 percent claim to be binge drinkers, and not one of them receives SSI. While this might indicate that the homeless group includes individuals whose alcoholism is less likely to be combined with another problem for which eligibility is possible, it is more likely that the homeless include those who have not recently applied, or who have not been accepted to the program despite a problem that might indirectly lead to eligibility.

Another series of measures involves the four-point scale of alcohol symptoms (see Chapter 2). While having one or two of the traits on the scale might not lead to automatic eligibility for SSI, having all four probably should lead to eligibility. Symptoms include tremors and shaking, which are apparently SSI eligibility criteria. Among those who are not homeless, the proportion of those with one to four symptoms who receive SSI is: 6.1, 20.7, 14.3, and 17.4. It is striking that, even among those with all of the symptoms, less than one in five receives SSI; perhaps this program, in general, is not all that accessible even to alcoholics who are eligible. Even more telling, no homeless individual with alcoholism symptoms receives benefits. Perhaps, for both groups, and particularly for the homeless, alcoholism involves a life style or other problems that make it quite difficult to apply, despite no life-time proclivity to avoid welfare. Otherwise, it is possible that, as advocates claim, SSI regulations, procedures, and informal standards are such that alcoholics are not served very well so that few even apply anymore, particularly if homeless. And, given the differences among groups, the lack of benefits among the homeless might, for a small number of individuals, contribute to continuing homelessness.

Social Security benefits are also slightly more commonly dispensed among those who have homes, with 6 percent of the domiciled and 1 percent of the homeless obtaining such benefits. Among those over 65 years of age, only 38.3 percent who are currently domiciled receive Social Security benefits; neither of the two individuals who are homeless and responded to the question receive such benefits. Among those under age sixty-five, 4.1 percent of those with homes and only 1.4 percent of the homeless receive such benefits. This suggests that the homeless are less likely to receive these benefits at any age.

While so few individuals make use of the program as to make this difference a small one, it is interesting that, while 2.3 percent of those who have homes receive Veteran's Benefits, none of the surveyed homeless receive such benefits. We do not know whether each individual in each group is eligible for benefits, or not. However, of the homeless 28.5 percent have served in the military; of those who are not homeless, 20.0 percent have served. War veterans may have an easier time obtaining benefits, and 8.3 percent of the homeless and 7.5 percent of the non-homeless served in wars. Clearly, the lack of receipt of Veteran's Benefits by the homeless cannot be explained by differential military service. It might instead be one reason why some individuals who are veterans become homeless while others do not.

Levels of receipt are small for other programs. To be sure, the homeless do not receive energy assistance while a few of the domiciled do (the difference is statistically significant); but this is obvious, because the homeless do not pay for fuel. Differences are limited with respect to the other listed programs: emergency assistance, unemployment compensation, and Aid to the Aged, Blind, and Disabled. Only a small proportion of individuals receive any such benefits.

If there is any surprises at all in these last few measures, it is the rarity of Aid to the Aged, Blind, and Disabled and of emergency assistance. Both are temporary programs that can help in a crisis. Given the fact that many individuals told us that the Illinois Department of Public Aid desires to place individuals on SSI and take them away from GA, and uses the P3 program as a stop-gap, one would particularly expect a higher use of this program. Perhaps the difficulties of commuting between multiple offices discourages some individuals from applying; perhaps workers do not encourage SSI applications as often as is believed.

Those Who Receive Benefits. Even though the lack of benefits is related to homelessness, some individuals obtain benefits, yet continue to be homeless. This is one indirect measure of the possible problem with benefit size. The problem would be less likely to be the benefit if those obtaining welfare had special financial or other needs, and thus might be candidates for emergency aid, instead.

Cross-tabulations (not reported in the tables) were developed to begin to analyze this. One might expect such individuals to have unusually high expenses relative to income, or unusual problems that makes it more difficult for them to make use of their resources. Indeed, female headed-families are heavily overrepresented among the homeless who have benefits (they comprise 41 percent of those with benefits and only 6 percent of those without), and this might indicate that greater expenses are one cause of being homeless and also obtaining welfare.

Otherwise, the homeless do not appear to be unusually incapable of budgeting or unusually likely to have high expenses. For example, one might expect those with mental health problems to be unlikely to budget well, but there is no relation between mental hospital experience and obtaining benefits among the homeless; 20 percent of those who have benefits and 20 percent of those who do not have such experience. Binge drinkers might also be expected to budget less well, but binge drinkers are less likely, not more likely, to be obtaining benefits than other homeless individuals (they are 10 percent of those receiving welfare and 27 percent of those who do not currently receive welfare; the difference is statistically significant). One might expect recent migrants to be less able to make do on the same level of funds, but while the homeless who are receiving benefits have been in Chicago for shorter periods, 1,388 days compared to 1,909 days, the difference is not statistically significant. Those receiving benefits did not pay higher rent in their last home than those who are not receiving benefits; the rent individuals in each group paid is approximately $170 per month. Nor are they the less well-educated (they have 11.4 years of schooling compared to 11.0 for others: the difference is not statistically significant), who one might presume have more difficulty in budgeting. The only other statistically significant relation uncovered is that those who are receiving benefits are less likely to work than those who are homeless and are not receiving benefits (21 percent compared to 42 percent). Clearly, however, this does not explain why the homeless individuals who receive welfare are still homeless.

It will be noted, below, that AFDC is unique in that many of those who are receiving benefits had recently been discontinued; families might become homeless when a cut off occurred and remain homeless after re-applying. The policies of transitional shelters and perhaps treatment programs might help to account for this. However, when the above analysis is completed for those who are not residing in transitional shelters or treatment programs, results are similar. No new statistically significant relations emerge.

While it is not statistically significant, it should be noted that those who receive benefits and are homeless paid a higher rent before becoming homeless: approximately $186 compared to $150. And while the difference also is not statistically significant, 73.1 percent of those who receive benefits but only 58.7 percent of those who do not lived in a one-person household. These findings represent only very mild evidence that those who receive benefits and are homeless are likely to have unusually high expenses compared to other homeless individuals. It is more likely that the low levels of benefits put many in crisis--and that differences in the factors covered in other chapters thus explicate homelessness for these individuals (and their families).

Cut Offs. One other reason for the lack of benefits might be that those who are homeless are likely to have been taken from the welfare rolls recently, one access issue. This can be ascertained from our questions as to whether such cut offs had occurred during the last six months--we did not ask about events that were further away due to a belief that memories might be too uncertain.

Table 4.5 presents reasons for the cut offs for the entire sample. The table divides the sample into three groups: those cut off from GA, AFDC, and from any other program. This use of a combined "other" category was made necessary by the size of the relevant groups.

As the first such table suggests, 18 individuals reported that they were cut off of AFDC within the last six months, 57 were cut off GA, and 11

Table 4.5

Stated Reasons for Welfare Cut Offs[1]

	Percent Cut Offs In:		
	AFDC	GA	OTHERS
Missed appointments, other rule violations	18.4	66.6	0.0
Administrative or other mix-ups	14.9	7.2	8.3
Lack of address, residency proof	5.0	1.9	0.0
Moved	21.6	5.3	8.3
Change in circumstances	18.4	9.7	61.2
Other	21.6	9.2	22.3
Total N	16	56	10
Not giving reasons	2	1	1

[1] Food Stamps omitted.

Note: Numbers and percents are rounded; response categories are collapsed.

were cut off other programs. For AFDC and GA, these are generally not said to involve financial ineligibility.

For AFDC, listed problems indicate a general rigidity. In roughly one-fifth of the cases, the individual moved, and perhaps benefit levels did not keep up. Other stated causes that occur with some frequency include changes in circumstances (about 18 percent of stated reasons), missed appointments and other rule violations (18%), or administrative mix-ups (15%).

GA cut offs create quite a different picture. About two-thirds of the reasons given by the 56 responding members of the sample involve missed appointments, missed work-related appointments, or other, miscellaneous rule violations; all but a very small proportion of the reasons given in this category involve the missed appointments.

As has been mentioned earlier, the GA program includes a strong work program in which regular meetings about job search, or regular classes, are required. It is likely that a large number of these dropped individuals have had particular problems in making all of the required meetings. Particularly with the renewed interest in work programs in recent years, this problem bears a close watch. Indeed, when administrative mix-ups are added, about three-fourths of all cut offs involve some type of administrative issue that is not clearly related to financial eligibility.

The lack of a reasonable sample size precludes any detailed analysis of the differences between the homeless and those who are not homeless on all of these measures of benefit cut offs. Nevertheless, Table 4.6 presents reasons for cut offs among the currently homeless, separately. In general, a larger proportion of the homeless than those who have places to stay have

Table 4.6

Stated Reasons for Welfare Cut Offs Homeless Only[1]

	Percent Cut Offs In:		
	AFDC	GA	OTHERS
Missed appointments, other rule violations	15.0	61.6	0.0
Administrative or other mix-ups	25.1	6.7	12.4
Lack of address, residency proof	10.1	6.7	16.8
Moved	22.5	6.7	12.4
Change in circumstances, change in rules	10.1	6.7	16.8
Other	32.6	5.0	16.8
Total N	11	16	6
Not giving reasons	0	1	1

[1] Food Stamps omitted.

Note: Numbers and percents are rounded; response categories are collapsed.

experienced cut offs; about 18 percent as opposed to 13 percent. This difference, however, is small enough that it does not totally explain the difference in current receipt of welfare.

Surprisingly, however, about 60 percent of the reported cut offs in AFDC occurred among those who were homeless at the time of the interview, although the homeless group represents less than one-third of the entire sample. It thus is likely that the loss of residence is a result of cut offs. Apparently, when a cut off occurs, those very poor individuals who also have children quickly lose housing. Housing is apparently so difficult to obtain that an extended period of homelessness often develops once housing is lost.

The "other" category also includes many currently homeless individuals. Seven of these cut offs from other programs, or almost 70 percent, involve those who are homeless. For GA only 17, or 29.8 percent of the reported cut offs involve those who are currently homeless. The homeless individuals are, if anything, slightly less likely to report a recent GA cut off.

Cut Offs and Current Receipt of Benefits. The existence of a cut off within the last six months does not always imply that an individual or family did not receive welfare benefits at the time of the interview, because individuals can be discontinued and can then reapply and receive benefits. Information on this issue adds quite a bit to the analysis of access.

Among all of those dropped from AFDC benefits, it appears that only 25 percent were not receiving benefits at the time of the interview (these figures are not reported in the tables). Roughly three-fourths thus say they had obtained benefits once more. This situation represents something like welfare "churning" in which families are quickly dropped, and again, picked up on the rolls. But homelessness often occurs, in the meantime.

The picture is quite different for GA recipients. In this instance, 52 percent of those who have been cut off say they were not receiving GA at the time of the interview. At least in relative terms, it seems clear that GA cut offs are more permanent.

These differences between programs become even more pronounced when the homeless and those who are not homeless are compared. Among those cut off AFDC and who are now domiciled, 35 percent apparently were not receiving AFDC benefits at the time of the interview; for those who are homeless, only 17 percent were not receiving benefits at the time of the interview. Among those cut off GA and who had homes, 39 percent say they were not receiving benefits at the time of the interview. For those who were homeless, however, the corresponding figure is a much higher 83 percent.

While the size of the relevant groups are so limited as to preclude attempting tests for statistical significance, we suspect that the patterns demonstrate different relations of the two benefit programs to homelessness. In the case of AFDC, apparently a small number of families are cut off, but are quite likely to become homeless, as a result. After becoming homeless, such families seem to be housed in transitional shelters at which they are encouraged to reapply for benefits; the vast majority receive such benefits in short order. However, it apparently takes these families a good deal of time to again become established in some type of permanent housing. The cut offs precipitate a crisis that lasts far beyond the loss of benefits.

For GA recipients, those who are cut off and do not again receive benefits within the 6 month period are the most likely to be homeless. In this case, there is no evidence that the homeless individuals obtain benefits quickly once they become homeless. The statistics concerning GA suggest that, for those who lose benefits and receive them again within a few months, homelessness can be avoided or quickly reversed; single individuals may be less likely to fall into homelessness immediately upon a loss of income. Perhaps this helps explain why cut offs are no more common among the homeless than among the entire sample. For whatever reason, however, the ability to return to the welfare rolls varies and helps explain homelessness for GA recipients.

Unsuccessful Applications. Another possible reason for the non-receipt of benefits involves unsuccessful applications for benefits. Respondents thus were queried about any programs for which they had applied, but not received benefits, during the last six months, and reasons are presented in Tables 4.7 and 4.8.

Most of the reported unsuccessful applications involve the AFDC program, in which ten individuals report an unsuccessful application, and GA, in which there were 37 such unsuccessful applications. All other programs (not including food stamps, for which patterns are too bound up with other programs to be reported, separately) account for only ten unsuccessful applications, three of which involved SSI, three of which involved unemployment compensation, two involving Social Security, and one each involving aid to the aged, blind, and disabled and one unspecified other program.

Table 4.7

Stated Reasons for Unsuccessful Application for Income Maintenance Programs: Whole Sample[1]

	Percent Stating Reason In:		
	AFDC	GA	OTHERS
Financially ineligible	0.0	0.0	21.1
Ineligible - other rules	0.0	8.5	31.6
Could not prove eligibility (believed self to be eligible)	41.7	10.3	21.1
Lack of an address	8.3	13.6	10.5
Non-cooperative, missed appointment	8.3	18.8	0.0
Change in circumstances	0.0	3.4	10.5
Pending	22.3	17.2	0.0
Other	19.4	28.2	3.8
Number giving a reason	10	31	10
Number with no stated reason	0	6	0

[1] Food Stamps omitted.

Note: Numbers and percents are rounded; response categories are collapsed.

Table 4.8

Stated Reasons for Unsuccessful Application for Income Maintenance Programs: The Currently Homeless[1]

	Percent Stating Reason In:		
	AFDC	GA	OTHERS
Financially ineligible	0.0	0.0	0.0
Ineligible - other rules	0.0	25.4	42.6
Could not prove eligibility (believed self to be eligible)	35.1	7.9	0.0
Lack of an address	14.9	17.5	57.4
Non-cooperative, missed appointment	14.9	21.6	0.0
Change in circumstances	0.0	5.8	0.0
Pending	20.1	15.8	0.0
Other	14.9	11.7	0.0
Number giving a reason	5	14	2
Number with no stated reason	0	3	0

[1] Food Stamps omitted.

Note: Numbers and percents are rounded; response categories are collapsed.

Also similar is the abundance of non-financial issues, which is due to the rigidities we have suggested. For AFDC, by far the largest reason for a lack of eligibility is an inability to prove non-financial eligibility. In nearly each such case, the more detailed responses that were recoded for the table reveal that the alleged problem involved the lack of a birth certificate for the child or one of the adults. As advocates claim, this requirement, which is part of the necessary verification steps to avoid a federally defined error, is indeed bound up with the rigidity that accompanied the implementation of federal error rate controls. In addition, the fact that the lack of an address was cited by only one individual suggests that, as state rules indicate, a lack of an address is not an automatic barrier to receipt of benefits, and at worst only an occasional worker apparently misreads this policy. Finally, 22 percent of this admittedly low number of failures to obtain benefits occurs in instances in which the application is said to still be pending. A response to another question indicates that the time range for such pending cases varies from only 4 to 90 days; this does not seem to be excessive. We thus could not verify a strong tie between long pending periods and extreme poverty. However, one such individual was homeless.

The reported reasons for non-receipt of benefits for GA are a bit more difficult to analyze. Of 31 respondents, nearly 30 percent fall into the other category. Roughly one-third of these involve instances in which interviewers simply reported the reason as "other"; the remaining reasons were simply too unique to place in a category. Perhaps given the existence of a bit more discretion in GA, there were more instances in which somewhat peculiar reasons were given to those applying for benefits. These reasons might have been used in place of simply dismissing individuals who did not seem appropriate--no individuals say they were dissuaded from applying or from completing an application.

Otherwise, a small number of individuals report such reasons as a failure to prove eligibility (again, a lack of a birth certificate was common), the lack of an address, a missed appointment, an argument with a worker, or some other form of non-cooperation. Also listed is the failure to comply with other rules, which apparently involved work-related rules that individuals had previously disobeyed, giving rise to current ineligibility under the sanctioning program. In general, problems with such specific mandates as proving past management did not emerge.

Seventeen percent of the 31 individuals claimed that their cases were still pending. But it appears that many of the applications of individuals who did not respond or who were placed in the "other" category are also pending; 18 individuals answered a question concerning how long the case had been pending. For GA applicants, the modal time for a pending case was 90 days, but half reported times longer than this. The six longest times were between one half year and one year. Perhaps, on occasion, GA cases are held in the pending category for such a long period of time that significant problems including homelessness indeed develop.

Of the ten other unsuccessful applications, financial or non-financial ineligibility are among the most common stated reasons. Most such reasons are probably related to the basic nature of the program. For example, this includes individuals who claim that their employer did not contribute, they quit a job so that they were not eligible for Unemployment Compensation, or the respondents who were too young for Social Security benefits. Even so, in 21 percent of the cases, individuals felt that they were eligible but could not meet non-financial demands of proof.

Particularly given the lack of SSI benefits obtained by the sample members, one might expect a larger proportion to apply, and be turned down by the program. To repeat, we must conclude that the failure to apply is the larger part of the problem of access to SSI. Indeed, Chapter 5 will point out how difficult it is to help those who stay in overnight shelters and who have little contact with workers at such agencies.

But being turned down may indeed contribute to homelessness. For, as Table 4.8 notes, the homeless account for over half of the failures to obtain AFDC and 43 percent of the failures to obtain GA (but only 18 percent of other failures). Overall, those who are currently homeless comprise about 21 of the 51 (weighted) non-successful applications, or 41 percent, which is just short of a statistically significant overrepresentation. No clear pattern relating turn downs to later receipt of benefits are evident. In general, 46 percent of the very small number of individuals turned down for AFDC during the previous six months were receiving benefits at the time of the survey, as were 31 percent of GA turn-downs.

Combining Responses. The number of individuals who have been turned down or who had been turned away from any given program is relatively small. When all such individuals are put together, however, the numbers become much larger. As a proportion of all homeless individuals who had ever applied for benefits, 39 percent had been turned down or had been dropped from some program during the last six months. The corresponding figure for the domiciled is 27 percent. The difference is statistically significant.

Thus, it must be concluded that the failure to be granted or to continue benefits for which one is financially eligible may in general be a cause of homelessness among the very poor individuals in the sample. However, this general "cause" is more important for some programs than for others. And it does not explain all of the differences in receipt among the homeless compared to those who are not homeless. That is, when the individuals who have been turned down or cut off and are not now receiving benefits are discounted, it is still true that 73 percent of the homeless who have ever applied currently obtain income maintenance benefits, as do 89 percent of those who are not homeless and have ever applied. The difference is statistically significant.

Another implication is that fairly significant proportions of the entire sample have recently been cut off or have failed to obtain applied-for benefits. While no obvious control group exists, it is likely that this set of problems contributes to the crisis all members of the sample are experiencing. Adding together responses, about 26 individuals have been cut off or failed to obtain AFDC, while 20 individuals had such an experience with programs other than GA or AFDC. Clearly, the greatest issues involve GA, because 16 percent of the entire sample, or 87 individuals, were either cut off or applied but did not receive benefits.

There also is some evidence that those who have been denied benefits are more vulnerable than the typical individual who has ever applied for benefits. Such individuals might be less able to deal with complicated rules. The cut off or denied individuals are, to a statistically significant degree, more likely to be binge drinkers (chi-square = 6.87) and to have a higher score on the GSI, the measure of psychiatric symptoms

(F = 4.89). There is no significant difference in the proportion who have worked in the last thirty days, suggesting that those who have been cut off or denied are not more likely to have other sources of support.

Toward a Further Explanation of Non-Receipt

Even so, some may note that access issues cannot be found to be the entire problem. Roughly 20 percent of the homeless do not receive benefits because they never applied; about 39 percent have recently been cut off or turned down and are now homeless, even though many now receive benefits from some program. Forty-five percent obtain benefits and are still homeless, in part for reasons to which we have alluded (i.e., the cut offs and turndowns in AFDC). What about the residual, that is, those who are not receiving benefits and have not recently been involved with the welfare system?

The most obvious claim is that preference or an inability to apply accounts for the lack of recent experience. But Table 4.9, which reports some characteristics of these individuals compared to those homeless individuals who are receiving benefits or who have recently been turned down or cut off, does not prove this. There are 56 such individuals, who can be compared to the 83 who either receive benefits or have recently had experience with at least one income maintenance program.

One view thus might be that those who no longer receive benefits have given up due to previous, negative experiences. However, the table notes that those who have not recently received welfare, but had at one point in time received benefits, were not more likely to report having experienced a problem with a social agency or with the welfare system. They are slightly

Table 4.9

Comparisons Among Those with Welfare Experience:
Currently Homeless

	Among Those With No Recent Experience	Among Those With Recent Experience	Total Respondents
Percent Male	81.0	38.9**	139
Percent Black	63.9	77.2	137
Average Age	37.8	32.6**	139
Percent ever had problem with social agency	52.1	42.8	140
Percent ever had problem with welfare agency	28.7	24.3	140
Percent believe they do not need welfare	24.4	11.0*	139
Percent believe welfare is embarrassing	32.2	32.6	139
Percent who cannot get to an office	30.8	33.3	137
Percent ever in a mental hospital	22.0	21.3	138
Percent who are binge drinkers	32.1	10.5**	137
Percent who had been in the military	40.2	15.9**	134
Percent worked in last 30 days	44.1	19.8**	137
Percent agreeing with:			
Street people are easy to get along with	38.9	32.8	108

(Continued on next page)

Table 4.9--Continued

	Among Those With No Recent Experience	Among Those With Recent Experience	Total Respondents
Percent agreeing with:			
It's easy to get things to eat and drink on the street	40.3	24.1	107
It's dangerous to live on the streets	91.6	94.6	116
People look at you funny when you don't have a permanent home	85.0	89.6	112
It's hard to find a place to sleep on the street	86.8	91.8	111
I like going when I want and sleeping when I want	69.1	77.1	133
I feel I have a lot in common with other people who do not have homes	59.8	53.1	132
Percent receiving food from homeless friends, past 30 days	21.0	9.4	117
Percent receiving cash from homeless friends, past 30 days	21.5	15.9	117
Percent receiving information from homeless friends, past 30 days	22.1	16.8	116

* $p < .05$
** $p < .01$

Note: Recent experience is defined as a) currently receiving welfare, and/or b) turned down or cut off in last six months.

Numbers and percents are rounded.

more likely to believe that they do not need welfare, at present, but share no other negative images of welfare (selected opinion items are reported in the table; there were no statistically significant differences among the non-reported opinion items).

Another view might be that this group of individuals cannot as easily obtain benefits due to pathology or alienation. But the group that is not now obtaining benefits is not more likely, to a statistically significant degree, to have been in a mental hospital. Once again, the stereotyped view of the mentally ill as unable to obtain benefits is not confirmed. To be sure, individuals with no recent experience are more likely to be binge drinkers, and more likely to have served in the military. But both traits also correlate to sex, and more women than men are currently receiving welfare; these relations may not be convincing evidence. Because so many live alone and not with families, problems with the GA system, itself, are indeed a more likely issue.

It is also possible that those who have not recently applied have become part of the "street culture," and believe they can, or actually do, survive without benefits somewhat more easily than others. More detail on the measures will be presented in Chapter 5, but a series of items representing the belief in this culture were cross-tabulated against recent experience with welfare. The results demonstrate few differences, and no statistically significant differences. Those who have recently applied and those who have not are rather similar on beliefs about how easy they believe it is to get along with street people, danger, the perception that street people are stigmatized, or the perception that the individual has much in common with others who are homeless. There are no differences in the propensity to obtain information or cash from others who are homeless. In addition, those who have not recently applied for welfare are slightly more likely to obtain food from others who are homeless; 21 percent report obtaining food in the last thirty days as opposed to 9 percent of those with recent welfare experience. And similarly, 40 percent of this group feels that it is easy to "get things to eat and drink on the streets," while only 24 percent of those with recent welfare contact respond positively. But these results are not quite statistically significant at the .05 level, and in each case, only a minority of those who have no recent contact with the welfare system respond affirmatively.

On the other hand, nearly half of the group that is not receiving benefits work. Perhaps receipt of benefits is less important for such individuals. These individuals also tend to be younger; perhaps to a small degree, those who do not receive benefits are more self-sufficient.

In short, there is mild evidence that some of those who fail to apply feel that they do not need welfare. Some may have other ways of getting along--either with the help of friends or with work. But only a minority demonstrates such attitudes or behaviors. Clearly a large group of those who are not receiving benefits do not have negative attitudes toward welfare, do not have traits that might indicate less of an ability or desire for benefits, or do not work. There is some possibility that these individuals would be willing to obtain benefits.

CONCLUSION

This analysis provides differential support to the four major issues. Insofar as the size of the grant is concerned, there is clear evidence that extreme poverty is a result of inadequate grants in AFDC and GA. Because a reasonable proportion of the sample receives welfare (even discounting those recently cleared), does not have unusual signs of problems in budgeting, yet is homeless, the grant size must contribute to the problem. But, obviously, the vast majority of those receiving grants do not become homeless. Further, so few of those receiving SSI are homeless that it is likely that this grant is sufficient to avoid this state.

The lack of responsiveness to individual needs, a second issue, is clear in the limits to emergency programs. However, analytic evidence is limited because we cannot compare those adequately helped and those not adequately helped by programs. One can only make a guess that such aid could help avoid homelessness for those who lose a dwelling or need a down payment, for example.

The possibility that the homeless are unwilling or unable to use programs is not supported in total, given the high lifetime use of welfare by the homeless, and the lack of strong relations between most measures of pathology and alienation and lack of program experience. Some minority of the homeless does appear to prefer independence to welfare, however. The most important issues involving individual problems seem to suggest a different logic, that the difficulty of applying and personal problems may interact with the nature of programs and behavior of mental health workers to favor the use of GA over SSI, even for those who might be disabled. Thus, in opposition to the common views, those who have been in a mental hospital are as or more likely as others to obtain some welfare benefits. But few such individuals (especially the homeless) obtain the more adequate SSI.

It is very clear that, even among the very poor, the probability of being homeless is most highly tied to the lack of receipt of income maintenance. This lack of benefits is particularly apparent for the GA program, for SSI, for Social Security, and for Veteran's Benefits. Our best guess is that the underrepresentation of the currently homeless in these programs is not due to a lack of eligibility for the benefits, but to a lack of receipt of benefits for which individuals were eligible.

Chapter 5

Services and Supports in Chicago

The lifestyle and daily problems of the homeless are said to be important for at least two reasons. First, the hardships of coping day-to-day may reduce the homeless individual's ability to escape homelessness. That is, without services from others, the problems of the homeless may be so great that the motivation and physical energy needed to escape are lost. Second, the failure of formal and informal support systems is said to increase both the difficulty and the risks of life on the streets. Indeed, although this has not been as widely acknowledged, the lifestyle of the very poor, in general, may also be difficult. One must determine whether the homeless are unique in lacking access to those basic life necessities of companionship, social support, or even adequate nutrition. This chapter identifies such problems and also examines existing programs.

THE ROLE OF SERVICES

Beyond the information gathered from the survey, we collected little data on the general life-style of the homeless. However, to better understand the role of services that might deal with problems, we conducted interviews with service providers and policy makers in Chicago. We will look both at services targeted for the homeless (such as shelters, drop-in centers, meal programs, etc.) and at other services which are not targeted but which seem particularly relevant.

The Shelter System

Budgets. There are two major types of shelters: overnight shelters, which house individuals one night at a time, and transitional shelters, which house individuals for more extended periods. Overnight shelters tend to operate on very low budgets, using donated goods and volunteer staff. Many are located in churches, and therefore are not generally required to pay rent. Average budgets appear to range from $18,000 to $35,000 per year for shelters which house approximately 30 people. This represents a yearly cost of between $600 and $1166 per bed. One overnight shelter reported a yearly budget of $90,000 but this shelter also provides a full meal and evening drop-in hours, along with an active advocacy program with several professionals. Larger, mission-type programs also exist and have larger, but difficult to estimate, budgets.

Average costs for transitional shelters tend to be much greater and to vary to a greater degree. Yearly budgets range from $121,000 for a 75-bed shelter to $1.2 million for a 120-bed shelter. For these extremes, the yearly per-bed cost ranges from $1,613 to $10,000. However, the typical transitional shelter appears to spend more in the area of $3,300 per bed per year.

If we look at trends in public funding, great progress has been made. Total funding for shelter and drop-in center operation has increased from $277,050 in 1982 to $6,693,793 in 1987. The largest increases can be seen in the amounts provided by the City of Chicago's Corporate Fund and the State of Illinois' line item for shelters in the Public Aid budget, each of which increased from zero in 1983 to approximately $3 million in 1987. Other governmental funds allocated by the city include the Community

Development Block Grant (roughly $200,000 allocated per year for shelters), the Community Services Block Grant (approximately $260,000 allocated between 1982 and 1984), and Service Tax Interest ($72,000 allocated in 1987).

Smaller but significant amounts have been provided by various public sources for shelter rehabilitation. Total amounts have increased from $56,362 in 1984 to $1,825,643 in 1986. Most of this funding has come from the Community Development Block Grant.

Many shelters also receive funding from foundations, corporate giving programs, and direct contributions. The largest provider of such private funds has been the Chicago Community Trust, whose Basic Human Needs initiative distributed approximately $4 million between 1984 and 1986.

Shelter Capacity. Given budget changes, the past five years have seen a dramatic increase in the numbers of available beds in both overnight and longer term shelters. In 1983, Chicago had a total of 891 shelter beds for the homeless. At the time of this writing there are 2,542 shelter beds, plus some 600 beds in "warming centers" (a type of seasonal overnight shelter). In early 1983, there were 395 beds in overnight shelters. Since that time, overnight beds have grown to a current total of 1,458. In 1983 there were 496 transitional beds, including 473 for women with children and intact families. The current total is 1,084. Of these, 840 beds are designated for women with children and intact families.

Despite increases in shelter beds, shelter operators report continuing problems with demand. They say they must turn people away, especially in winter. One transitional shelter reports having turned away half as many people as were served in the first fourteen months of operation. Some overnight shelters and warming centers accept more clients than their official capacity, as long as there is physical space.

Under an ideal shelter system proposed by advocates for the homeless, clients would enter the system at the overnight shelters, progress to transitional shelters, and finally be placed in long-term, low-cost housing (Sakano, 1981). But in Chicago, it appears that few individuals in fact make such progress. This is because the two shelter systems largely serve different clientele: the overnights serve single men and women while the transitionals serve intact families and single women with children.

As there are few, if any, overnight shelters for families, transitional shelters often function in an overnight capacity for those families needing only one or two nights' stay. Although single women are accepted in some transitional facilities, the facilities primarily serve women with children. In general, there are few beds for intact families or for men with children. Most transitional shelters are designated for women with children only, and indeed, most users of transitional shelters are these female-headed families.

Along with the need for overnight facilities for families with children, there is a serious lack of transitional shelters for single men. Presently, there is only one small shelter offering transitional beds for this group. Men live in several shelters on a semi-permanent basis by acting as volunteer staff, performing cooking and other housekeeping duties. Often inpatient alcohol treatment programs serve as transitional shelters for men.

There is one shelter which is wheelchair accessible and designated for the handicapped. Although several transitional shelters are also accessible, there is a lack of appropriate emergency transportation for wheelchair-bound clients--at the current time, many are transported in police wagons. There is also a shortage of shelter beds for homeless people recuperating from illnesses or injuries but no longer needing hospitalization.

There are several mental health agencies which provide emergency housing. To receive these services, however, clients must be suffering from emotional crises beyond that of needing shelter. Generally, clients must have a history with the agency and must not be violent.

Types and Characteristics of Shelters. Overnight shelters tend to be located in very poor neighborhoods--Uptown, areas surrounding the Loop, the near West Side, Lawndale. Overnight shelters are generally located in church basements or former school buildings. The stereotype of shelters for the homeless accurately describes the operation of overnight shelters: homeless people line up at night, sleep on a cot or foam mat on the floor, are given snacks, and are sent back out on the streets in early morning. Intake procedures tend to be very minimal, usually requiring only a signature. Thus, within their capacity, overnight shelters should provide ease of access.

However, services are few and staff receive only minimal training. There is no limit to the number of nights individuals may stay, although individuals must apply each night. Snacks are usually coffee and bread with government surplus butter or cheese. Some theorists have suggested that moral attitudes about the homeless demand that shelter clients leave the shelter during the day to attempt to find work (McGerigle and Lauriat, 1983). While this may be true in part, overnight shelters are often required to limit their hours of operation because of the unavailability of volunteers and because of other demands for the space.

Generally, overnights are staffed by volunteers who, as part of their training, are provided information to deal with medical emergencies and unruly behavior. Even so, they are ill-equipped to assess the severity of mental problems or to handle psychotic episodes; their only options are to evict the person or call the police.

Transitional shelters are located in unused convents, storefronts, six-flats, and in one case, a former Holiday Inn. They are located in more neighborhoods than are overnights and are often run by established social service agencies.

Transitional shelters require more of clients than overnight shelters but they also provide more services. Transitional shelters in theory have strict eligibility requirements. Most refuse to take clients with a history of mental illness; they fear possible disruption and its effect on children, and claim that they do not have staff trained to deal with such problems.

In most transitional shelters, homeless families are not required to leave the facility during the day. Meals are provided and clients are often required to assist with meal preparation. Most transitional shelters have extensive rules, and many require clients to sign a contract. Some of these rules concern daily behavior: residents are required to participate in house activities, supervise the children, and perform chores. In several missions, women are expected to wear skirts and attend church services. Children are enrolled in local schools and are expected to attend.

Other rules pertain more to preparing the clients for independent living. Transitional clients usually participate in personal and financial counseling. As Chapter 4 notes, almost all such shelters require non-working adults to apply for income maintenance programs and to save the resulting income in a trust fund; this money will be used for their security deposit on an apartment when they leave the shelter. One shelter operator noted that if the husband "drank up" their first check, the family could stay but he would be put out.

Transitional shelter staff attempt to help families and single women escape homelessness through their efforts to locate permanent housing and teaching residents to obtain and manage income. Unlike overnight shelters, staff do not expect to see their clients again after a stay of perhaps 90 to 120 days. Indeed, most transitional shelters will not allow families or individuals to return for repeated stays. A northside shelter operator stated, "If we didn't help them the first time, we probably wouldn't be able to help them again".

Other Services. Overnight shelters generally only offer a snack and a warm place to sleep for their clients. In a few overnight shelters, employees or volunteers perform case advocacy--this generally involves making applications and resolving problems with income maintenance programs, and making referrals to other agencies. A few overnights employ social workers to do this work and to provide limited counseling. One overnight shelter has established relations with a neighborhood day labor agency so that the clients may earn money. As stated earlier, transitional shelters tend to offer many more services, with the stated goal of facilitating clients' movement toward independent living.

Additional services may be offered which promote personal change: General Equivalency Diploma classes, parenting and budgeting classes, counseling, Alcoholics Anonymous meetings, and groups for women and veterans. Religious organizations may offer Bible studies classes, pastoral counseling, or etiquette classes. A few shelters offer Headstart or grade school classes on the premises.

While shelters generally seem to be doing the best they can with limited resources and overwhelming demand, unresolved service needs are painfully obvious. Although the problem is more extreme for overnight shelters, by and large shelters for the homeless are not connected to other elements of the social service network. Many advisory boards to shelters do not include representatives from local social service agencies, or, in some cases, any persons knowledgeable about services available in the surrounding area (Albrandt, 1986).

Service providers mentioned that certain groups need special services: outreach to Spanish- and Polish-speaking homeless, alcohol treatment programs for the indigent beyond detoxification centers, special programs for those dually diagnosed as mentally ill and substance abusers. Others said that new services were needed, including a revolving loan fund for rents and security deposits, more people to help locate available housing, and transportation (particularly for women and those with physical problems).

Several organizations exist to provide technical assistance and advocacy for the shelter network. The Mayor's Task Force on the Homeless has primary responsibility for the allocation of public funds for the operation and rehabilitation of shelters. The Community Emergency Shelter Organization (CESO) facilitates the creation of more shelters through public education efforts and provides technical assistance to potential shelter operators. Through outreach to religious denominations, the Interfaith Council for the Homeless encourages voluntary response to the problem of homelessness, especially through its winter-time Warming Center Program. In addition to providing a forum for the discussion of problems experienced by shelter providers, the Chicago Coalition for the Homeless advocates for the immediate and long-term needs of the homeless. The Chicago-Gary Area Union for the Homeless is a group of homeless people who work to improve shelter conditions and to increase the amount of low-income housing.

Alternative Forms of Temporary Housing

To complete the picture, it should be noted that there are several types of agencies which also provide temporary housing to homeless people. Some of these programs run drop-in centers or provide alcohol treatment and make a small number of beds available to particular clients. Such clients may have special needs such as being unable to climb the stairs at a nearby shelter. Others may work for the program without pay, receiving room and board as compensation for their work. Several rehabilitation programs shelter a small number of people who are then encouraged to enter the program.

There are several very small shelters that have avoided municipal review processes required of larger shelters. Additionally, the Catholic Worker Movement operates two houses in Chicago where homeless people may stay for indefinite periods. Several church congregations on the West Side offer temporary housing in apartments for families and also take single adults into their homes. There also is a shelter for AIDS victims who have been evicted because of their disease.

In addition, the American Red Cross is often called in when families become homeless through fire, flood, and other disasters. Referrals come from the Department of Human Services, the Fire Department, Red Cross volunteers, or the victims themselves. In FY 86, 8,431 individuals comprising 2,253 families were served. Roughly one-third of these families were provided with temporary housing in a hotel or shelter. Most Red Cross clients are renters and approximately 40 percent receive public assistance.

The Red Cross sees its role as providing immediate, time-limited assistance to victims of catastrophic events; therefore, clients are given help for three days. Almost all Red Cross clients receive financial assistance, with payments to families averaging $204. In addition to providing emergency food and clothing, Red Cross caseworkers also help individuals and families to obtain medical help, counseling, public assistance, and other forms of material assistance.

Health Care

Other than shelters, one of the few services specifically targeted for the homeless is a special medical project called Health Care for the Homeless. Funded by the Robert Woods Johnson and Pew Memorial Trust foundations in 1985, these demonstration programs were founded in 19 U.S. cities. Their mission is to provide medical and social work services to homeless people through intensive outreach activities. While this goal is accomplished in different ways in other cities, the Chicago Health Care for the Homeless Project sends mobile teams to approximately 12 overnight shelters and drop-in centers. This year the Health Care for the Homeless Project began a cooperative outreach project with Thresholds, an agency serving the chronically mentally ill.

Drop-in Centers

There were 18 drop-in centers, or "day shelters," for the homeless operating in Chicago in fall 1987. Twelve of these are at least partially funded by the City of Chicago. Some are free-standing agencies with their own boards of directors. Of the eleven drop-in centers which are not free-standing, four are associated with overnight shelters, one with a treatment program, and six with larger, multi-purpose social service agencies. Three centers are for women only, one for American Indians, and one for homeless youth.

Drop-in centers have minimal intake requirements--the door is open to all who agree to follow the rules. Nevertheless, one could view drop-in centers as a primary resource for the homeless and near-homeless. These centers all provide shelter from the elements, food, and social contact. Most drop-ins offer shower facilities, counseling, free clothes, and an address to receive mail. Other immediate needs which may be met by drop-ins are health care (often through the Health Care for the Homeless Project), carfare, small loans for medications or other emergencies, and in the case of at least one center, free shaves and haircuts when a volunteer is available. Drop-in centers operated by religious groups may also offer Bible classes and religious counseling.

Some drop-in centers provide case management and advocacy services to help clients escape from homelessness. Staff members help clients understand various official notices, negotiate with workers from the Illinois

Department of Public Aid, locate shelters or permanent housing, and make referrals to substance abuse and mental health programs. Some centers with more structured programs may offer group counseling and vocational counseling. Drop-in center staff often transport intoxicated clients to detoxification centers. While voluntary referrals to state mental health facilities are common among the homeless, drop-in center workers sometimes have to take an active role in having mentally ill clients involuntarily committed.

Low-Income Housing

In Chicago, only a few organizations address the problem of permanent housing for the homeless. One residential program, Housing Opportunities for Women (HOW), was created specifically to house homeless women for longer periods than those spent in transitional shelters. Sometimes referred to as "second-stage" housing, HOW serves those having difficulties living independently, often because of substance abuse or mental health problems. Another group which is trying to create more low-income housing for single individuals is the Lakefront SRO Corporation. This group purchases old SRO (single room occupancy) hotels and apartment buildings and prepares them for occupancy.

The Single Room Operators Association is a coalition of SRO hotel owners and other persons concerned with the preservation of this housing stock. This group formed after a successful lawsuit forced the city to conduct research on SRO hotels. The Association was influential in the establishment of the Low-Income Housing Trust Fund, which will use monies from real estate developers and other sources to create more low-income housing in Chicago.

Food Programs

Food resources available to the homeless in Chicago generally take two forms: hot meal programs and food pantries. Neither program is targeted for the homeless--they are available to all who claim need. But, for people who barely have enough income to pay rent, the existence of free meal programs may help some avoid becoming homeless (McGerigle and Lauriat, 1983).

At a glance, there appear to be many useful agencies. At the time of the survey, there were around 40 meal programs operating in Chicago, serving approximately 4,100 people. At the same time, there were 600 food pantries. Some of these were only in operation for a few hours on one day per month. Others are open every day. Because food pantries tend to operate on limited funds and volunteer help, food pantries are more likely to go out of business. Thus, it is difficult to determine the number of pantries operating at any given time.

Umbrella Organizations. There are several large organizations which provide food and organizational support to the various food programs. Chicago is the home of Second Harvest, a national organization which obtains food supplies from some 250 food manufacturers and distributes them to 16,000 food banks and social service organizations across the country.

Chicago's largest food bank and the major recipient of Second Harvest supplies in the area is the Greater Chicago Food Depository. The Depository has seen a rapid growth in demand for its services. In 1979, 85 agencies belonged to the Depository and received some 500,000 pounds of food. By

1984, 14 million pounds of food were distributed to 525 agencies. The amount of food distributed dipped slightly in 1985 to 12 million pounds, which was estimated to serve 550,000 people. The Depository prepared 300,000 food boxes for the Department of Human Services in 1986--food worth over five million dollars.

The Anti-Hunger Program of the Church Federation of Chicago provides fresh produce to supplement items received from the Depository. The Church Federation estimates that it feeds approximately one million people per year through 125 organizations.

The Self-Help And Resource Exchange (SHARE) program is sponsored by the Roman Catholic Archdiocese and distributes food to approximately 14,000 people monthly. Unlike other food programs, participants are charged a minimal fee ($14 per month) for which they receive 45 pounds of food. Participants are also required to donate three hours of their time per month for volunteer work in their parishes, the SHARE warehouse, or other locations. As of January 1986, 118 parishes and community organizations served as local distribution sites for SHARE.

In addition to meals served in their shelters, the Salvation Army operates nine meal programs in Chicago, termed "front-line feeding programs". Each program serves hot lunches five days a week to 100 - 250 people. On a daily basis, the Salvation Army's front-line feeding program feeds 1,650 - 2,100 people in various poverty-stricken neighborhoods of Chicago.

Another organization involved in the provision of food is the Food Justice Program. While this program does include a small outreach service which supplies food to the elderly, its main functions are in the areas of case and systemic advocacy. The Food Justice Program gathers data on hunger and food distribution, and performs legislative advocacy, in addition to operating a hotline which refers people to pantries and attempts to resolve food stamp problems.

All of the above organizations and several other social service organizations (Catholic Charities, the Jewish Federation, and several smaller groups) are members of the Chicago Interagency Food Network (CIFN). CIFN exists to coordinate distribution of supplies and to raise funds. The Network also provides technical assistance to food program operators in monthly presentations.

Specific Food Programs. There are of course some operational problems. Food programs are almost always located in churches. This fact has facilitated the creation and operation of food programs because churches naturally draw volunteers and other resources together for altruistic purposes. But, one disadvantage of church involvement in food programs was mentioned by members of various umbrella organizations: many churches, particularly in poorer areas, use tangible services such as food distribution as a means of attracting new members. Competition for potential clients (and church members) can lead to non-cooperation between programs. While some pantries will cooperate in transporting goods or sharing surpluses, others jealously guard their turf, sometimes preferring to forego food donations rather than sharing with another pantry.

Food programs receive their supplies from the above-named umbrella organizations, through food drives at their own or other parishes (particularly in the suburbs), and through purchases with Federal Emergency Management Agency (FEMA) monies or other funding. Both pantries and meal programs operate through extensive use of volunteer help, having few if any paid staff.

While meal programs tend to operate on more regular schedules than pantries, many only offer one or two meals per week. In several areas of the city, meal providers have collectively planned their hours of operation, to avoid duplication. The greatest amount of coordination can be seen in Uptown, where a needy person can receive a free meal at every mealtime of the week except for Sunday morning.

Most meal programs have an open admission policy with very minimal intake requirements. This is less true of food pantries, which generally require the client to register on the first visit and to provide proof of address and income. As pantries experience increased demand, there is more concern about "pantry-hoppers"--people who go from one pantry to another to receive more than their share of food supplies. Members of various umbrella organizations stressed the need to create record-keeping systems to prevent such abuses.

Because of their requirements to document income and address, pantries are more likely to serve domiciled people. Some have staff or volunteers who try to help clients with a multitude of problems: negotiating conflicts with landlords or public assistance workers, locating a place to stay, or finding other needed services.

General Social Services

Some theorists suggest that recent increases in homelessness may be partially attributable to inadequacies of the larger social service system. Specifically, they believe that there are insufficient services available to very poor people and that existing services too often focus on personal change instead of providing more tangible forms of assistance (Rousseau, 1981; Baxter and Hopper, 1981; Hombs and Snyder, 1982).

Funding Cutbacks. The last ten years have not been kind to social service appropriations and this in theory may somehow affect homelessness. Recent studies by the Urban Institute show that total government funding received by non-profit agencies decreased by 6 percent from 1981-1982 and by 7 percent in 1982-1983, excluding funding for health care. These cuts are significant because two-thirds of all Chicago area non-profits receive public funding, with such funding making up an average of one-third of their total budgets. Gronbjerg, Kimmich, and Salamon (1985) state that government cutbacks act as a "two-edged sword" with non-profits--in addition to decreasing the amount of actual funding, such cuts probably increase client demand for services because of corresponding cuts in income assistance programs.

These cuts also take on more significance when one considers their effect on different services and the implications for homelessness. Between 1981 and 1982, employment, housing and advocacy agencies lost 12.1 percent of their government funding, social service agencies lost 8.8 percent, and multi-service agencies lost 8 percent. Similar cuts were made in 1982 and 1983. Non-profit employment and training programs lost 26 percent of their government funding from 1982 to 1983, housing and community development agencies lost 16 percent, public health efforts (excluding Medicare and Medicaid) lost 7 percent, and general social services lost 3 percent (Gronbjerg *et al*., 1985).

Although federal spending generally increases in recessionary times to counteract increased needs and state cutbacks, this did not occur in the early 1980s because of deliberate decisions by the Reagan Administration. When one excludes medical benefits, federal spending for social services decreased by 35 percent from 1980 to 1982. Examining several service areas relevant to homelessness, federal spending for housing and community development decreased by 9 percent from 1982 to 1983, while employment and training funding decreased by 10 percent and social services funding increased by 5 percent.

Cutbacks of similar magnitude occurred at the state level during the same time period (1982-1983). State funding for social services was cut by 18 percent and housing and community development efforts decreased by 8 percent. Although funding for employment and training increased by 62 percent, this program was very small.

Often when federal expenditures are reduced, states attempt to compensate by increasing their expenditures in the areas experiencing cutbacks. This did not happen in Illinois in the early 1980s. In fact, Gronbjerg and her colleagues conclude that most of the cutbacks felt by Chicago area non-profits were more the result of state than federal reductions. Excluding health care and income assistance, 15 percent of state funding to non-profits was cut by the State of Illinois from 1982 to 1983 (Gronbjerg, Musselwhite, and Salamon, 1984).

As federal and state funding declined in 1982-83, local funding increased slightly (by 1 percent, excluding health care and income assistance expenditures). However, this increase could not compensate for the losses at the other two levels of government. Although funding specifically targeted for services to the homeless has increased dramatically in the past few years, in some cases this may have happened at the expense of other social service programs.

In sum, there has been a great increase in the most immediate services involving food, shelter, and perhaps health care. But as one looks to prevention or long-term rehabilitation, little is offered the homeless. Nevertheless, a number of general social service agencies provide services that influence the problem of homelessness.

Private Agencies. Several large private agencies, such as United Charities and Catholic Charities, have provided temporary housing to homeless people through the use of hotel vouchers. In some cases, this was accomplished through the use of FEMA funding in its first years of operation. Catholic Charities discontinued this practice after opening their own shelters. In other cases, vouchers were made available through the agency's own funding or through one of two funds administered by the Chicago Community Trust, to be described below.

Many social service agencies prevent homelessness for some individuals who are at risk. Clients receive assistance for a multitude of financial problems which, if left unchecked, would probably result in loss of housing. Delivered in a context of budget counseling, such financial crisis intervention may include negotiation with landlords, the payment of utility bills and mortgages, advancement of monies for miscellaneous costs when a new job is started, or carfare for attending job interviews or doctors' appointments.

Funding for these services often comes from the Sherburne M. Earling Working Mothers Trust and the Fred B. Jones Special Fund, both administered by the Chicago Community Trust. These two funds allow agencies to provide various forms of material assistance to their clients, including bus tokens; money for rent, security deposits, utility payments; and expenses associated with starting work, such as day care, work clothing, and transportation. Approximately $160,000 was distributed through these two funds in 1986.

People who are at risk of becoming homeless clearly may benefit from a variety of services which help to bring economic or emotional stability to their lives. Churches and community agencies provide material assistance in the form of free food, clothing, and furniture. Through intervening in crisis situations, some agencies prevent homelessness by attempting to resolve disputes with landlords, or with relatives or friends who have offered a temporary place to stay. Particularly with regard to evictions, preventive services are greatly needed and seem to be currently in short supply.

State Services. While most of the service network of Chicago is run through city departments and private agencies, the funding is almost completely garnered through the state. The way in which state services operate is therefore vital to understanding the local service network. We will focus on expenditures involving the Social Services Block Grant.

In Illinois, rather than directly running programs, or officially administering them, virtually all programs are contracted. This process includes contracting to other state agencies, cities, and counties as well as to private agencies.

Without adjusting for inflation, the amounts allocated by the federal government for Title XX (and its successor, the Social Services Block Grant) have remained fairly constant. In 1977, $2.796 million was allocated nationally for Title XX while in 1985, $2.725 million was allocated for the Social Services Block Grant (Committee on Ways and Means, 1987). Because of inflation, the real value of these funds has been shrinking.

The state Title XX allocation in FY 86 was about $132.4 million. Including the local matching and general revenue funds, the funds available total approximately $320.8 million (Report on Projected Expenditures, 1985). While officials did not offer exact amounts granted to municipalities and agencies, it appears that such direct grants comprise the bulk of spending.

State officials have seen very little documentation to suggest that the homeless are major consumers of Title XX services. At best, we were told, a few services might in theory help the homeless or contribute to prevention. We suggested that employment and transportation services can be used to forestall homelessness; and that information, referral, and counseling services could be used to help with crises that can cause homelessness. However, no specific programs appear to address these issues. It may be that some homeless individuals make use of existing services for the very poor. However, if they do so, their usage must be documented elsewhere.

The major state initiative to deal with homelessness (outside of funds for shelters), we were told, involves the domestic violence issue. Administered through the Illinois Coalition on Domestic Violence, the funds generally go to residential programs to serve victims who have left their homes. Some programs have outreach or information and referral services that may help some avoid homelessness, but this service is not consistently offered. Statewide, expected expenditures for 38 domestic violence shelters for FY 86 were $6,589,200. This service is funded by both General Revenue funds and the Domestic Violence Shelter and Service Fund. It is expected to service 16,000 clients per year, statewide (Illinois State Budget, 1987).

Looking at funds administered by the Department of Public Aid (DPA), the employment funds are meant to provide services basically to General Assistance recipients, thus leaving out the vast majority of the homeless; social adjustment and rehabilitation services go largely to DPA clients directly. Few services appear to target the homeless.

Services provided by the Department of Rehabilitation Services in theory involve family support, employability development, and rehabilitation for the mentally and physically handicapped (which can include the homeless). However, homelessness does not appear to be a major priority of the agency. While requiring an address is prohibited by law, the application process for these services centers on one's residence, is long, and can be complicated. There are also difficulties with the provision of income benefits during training programs--the lack of which would tend to discourage the participation of homeless clients. In sum, rehabilitative services may have potential value for the homeless, but it appears that little effort has been made to accommodate their special needs.

City Services. In Chicago, if special funds are to be spent on the homeless--except when they are involved in programs for employment, detoxification, or rehabilitation--the city's Department of Human Services (DHS) is in theory the appropriate service provider.

The department's estimated budget is $100 million per year, with about 90 - 95 percent of these funds from the state. The city provides some matching funds, as well as "threshold" funding for basic administration, including directors of district offices and emergency services teams. While some services are provided at the central office where roughly 1,000 individuals are employed, there are also nine district offices, called Community Service Centers.

The 50 percent budget cuts in the early 1980s brought about a concentration on provision of concrete services. City programs are divided into a number of different branches. These include children's services, an office of dependent care, and the Chicago Intervention Network (CIN), which generally works with the police to control gang activity.

A new Youth and Family Service division also exists, which occasionally serves homeless or potentially homeless clients. Funded by the Community Services and Community Development Block Grant monies, and also corporate money, there are no official eligibility rules. There is an expectation that the majority of recipients be poor. This division is small with a total of about 70 people. It is the only generalist unit in DHS. However, even this division has very specific responsibilities, including the PATH program which, in cooperation with the school system, is meant to help children avoid dropping out of school. PATH also provides victim assistance for children who have been terrorized by gangs. The amount of time left for generalist activities appears to be small, although we did not systematically investigate this issue.

In theory, district programs can also deal with the homeless, but these programs are not generally established for this purpose. District offices administer the emergency energy program and distribute approximately 300,000 food baskets per year. Because of rapidly increasing demand in 1987, the department has recently decided to change its food basket policy, limiting the number of times one can receive this assistance from once per month to once per year.

The district offices can in theory advocate with the welfare offices. As noted above, however, these offices report only moderate amounts of contact with state workers. As one worker told us, advocacy had been part of her job in the past. However, as recently as 1986, pressures increased to limit this activity. Public defenders as well as state income maintenance officials confirmed that such advocacy has been reduced.

One unit of particular interest is the Emergency Services Unit (ESU). This unit was created by DHS to deal with emergency or crisis situations. Started during the mid-1970s as a crime control measure, it was originally supported with Law Enforcement Assistance Administration (LEAA) funds. From the beginning, responses to police calls were the highest priority. Partly for this reason, requests from the police continue to be answered first. Other requests come from district workers, or from the general public.

ESU staff must decide how to deal with emergencies. In many cases, workers refer individuals to what they deem an appropriate service--from income maintenance programs to emergency shelters. In some cases, emergency team members are sent out to deal with the crisis. Clearly, the team members are only able to cover a small proportion of the existing emergencies. According to 1985 figures made available to us by the unit, it received 91,072 calls and directly handled 14,253. Of the cases on which the unit directly acted, about one-third, or 5,735, were instances in which homelessness was threatened. In general the mobile teams are constantly active; there are three shifts of only three to five two-person teams. Given the small number of teams and the large number of potential emergencies, a priority scheme has been developed. The ESU rates homelessness a high priority, but not the highest; suicide attempts and domestic violence rank higher on the scale.

When homelessness is threatened, resource limits clearly have something to do with the response. Assuming that a team is available, the first priority is to determine if a family or friend might help resolve the crisis. Shelters, however, are the more likely alternative for calls that occur between 9 p.m. and 7 a.m. When shelters are full, the unit will make use of voucher or vendor payments, but only for families, the elderly, and the handicapped. According to DHS internal figures, vouchers were used for about 1,280 people in 1985, with an average stay of three to four nights. Once a voucher is used, the case normally is referred for follow-up to the department's Division of Youth and Family Services.

Because of the use of vouchers, the department claims that it never turns away families that require housing. However, this is not always the case for single individuals. Often, the officially sanctioned shelters are full, or inappropriate for singles. As a result, the final referral will be transportation to a shelter that is not on the official list because, for example, it mandates religious services. It is not clear that the unit can always insure that the individual is accepted, because a bus token might be the final service that is directly delivered.

There are other limits to the services provided. For example, teams may be called on to do a psychological evaluation before referring an individual to a shelter, to reassure the shelter that the referred individual is appropriate. Most shelters are reluctant to serve those recently released from mental hospitals. On occasion, a client will be denied services because he or she refused to be evaluated.

Because the unit responds only to requests, there is a possibility that many individuals with significant needs are not helped. For example, individual evictions are only directly handled by the Sheriff; there is presently no mechanism for referrals from the Sheriff's Department to DHS workers. DHS will act in a preventive fashion when an individual calls who is threatened with eviction, or when the Chicago Housing Authority's winter moratorium on evictions ends. The department's services are often requested by the court when an entire building is being emptied for renovation. However, most services to evicted individuals are provided after the fact, when a problem has already resulted in homelessness.

STATISTICAL RESULTS

The survey contains a moderate number of items relating to service use, as well as the coping patterns and day-to-day life of those in crisis. Because it contains information about the life circumstances of both the homeless and those other individuals in the sample, it is possible to make some attempt to distinguish the nature of the problems the homeless face from the problems of a broader sample of the very poor in crisis.

Access to Services

The relationship between service use and homelessness is currently not well defined. Some suggest that people remain homeless, and perhaps are more likely to become homeless, because of their reluctance or inability to use available services. Others feel that particular patterns of service use, most notably the underutilization of services, result from being homeless (Morse, Shields, and Hanneke, 1985; Crystal, Goldstein, and Levitt, 1982; Stevens, Brown, Colson, and Singer, 1983; Brown, MacFarlane, Paredes, and Stark, 1983; Roth, Bean, Lust, and Saveanu, 1985; Rossi, Fisher, and Willis, 1986).

Past Use of Services. Survey respondents were asked if they had ever sought help from agencies offering shelter, free meals, counseling, alcohol or drug treatment, and material goods (such as clothing, furniture, and food). Drop-in centers were also included, along with agencies that provide help with income maintenance problems, and finding employment and housing.

Table 5.1 presents these responses. Services are grouped by the type of assistance they offered: in-kind assistance, therapeutic services, and other services. Looking at the findings for all respondents in the sample, there is fairly substantial use of a variety of services. On average, respondents each used 3.5 of the 11 services listed. In particular, meal programs and employment services were heavily used. However, of the people interviewed at what we called a meal program, only 76.6 percent admitted to ever using this service, and only 36.5 percent said that they were currently using meal programs (this data not shown). That more people did not view the meal program as an "agency" is probably due to having been interviewed in a church, where most free meal programs are located, but which may not seem to be a meal program to respondents.

More tangible services were more likely to have been used. In addition to meal programs and employment agencies, 43.1 percent had stayed in a shelter and 52.7 percent had used agencies providing material assistance

Table 5.1

Percent Reporting Past Use of Services[a]

	Among All	Among The Ever Homeless	Among The Never Homeless
In-Kind Services			
Meal programs	67.6% (528)	68.0% (347)	66.7% (181)
Shelters	43.1 (528)	59.9 (348)	10.6** (180)
Material assistance	52.7 (529)	57.6 (348	43.5** (181)
Housing locators	28.8 (529)	38.2 (348)	10.7** (181)
Drop-in centers	24.3 (525)	31.0 (343)	11.6** (181)
Therapeutic Services			
Alcohol treatment	22.7% (529)	27.4% (348)	13.8%** (181)
Counseling, family service	21.3 (528)	23.3 (348)	17.4 (180)
Drug treatment	13.5 (529)	15.2 (348)	10.3 (181)
Other Services			
Employment	57.9% (529)	61.0% (348)	52.1%* (181)
Advocacy (public assistance)	19.7 (528)	22.3 (347)	14.7* (181)
Other	8.4 (525)	9.5 (344)	6.3 (181)
Job training[b]	45.6 (531)	45.8 (350)	45.1 (181)

[a] Figures reported as percentage of total weighted sample.

[b] From question asked in other location in interview.

* $p < .05$

** $p < .01$

Note: Numbers and percents are rounded.

(food, clothing, furniture). Other in-kind services saw lower but still substantial levels of use.

Therapeutic services are less available, so it is no surprise that they generally had a lower level of use. As shown in Table 5.1, 22.7 percent of all respondents had been in alcohol treatment, 13.5 percent in drug treatment, and 21.3 percent had been to a counseling or family service agency. Only 53.6 percent of the persons having serious alcohol problems (measured by a five-point scale of alcoholism symptomology) said that they ever received services from an alcohol treatment program, and only 2.6 percent say they are now receiving such services. Interestingly, 14.7 percent of the people who do not currently seem to have alcohol problems have received alcohol treatment services at some point (this data not shown).

There is a relatively high use of advocacy services for problems with income maintenance programs. Approximately one in five, or 19.7 percent, of survey respondents had such problems and had sought help. The "other" services reported in Table 5.1 included the Veterans Administration, hospitals, outpatient clinics and other medical resources, and various public services.

The homeless are often seen as unwilling or unable to take actions in their own behalf. Many feel that some people become or remain homeless because they fail to take advantage of existing services. Table 5.1 thus reports findings on service use comparing those respondents who have ever been homeless with those who have not. (This comparison is used because the questions about service use referred to lifetime use of various services.) In opposition to the common view, the ever-homeless are greater users of service than the never-homeless for all service categories.

For seven of the eleven service categories, differences between the two groups were statistically significant. The ever-homeless are more likely to have used material assistance agencies, agencies which help with locating housing, alcohol treatment services, and drop-in centers. The homeless were also more likely to use employment agencies.

As mentioned in Chapter 4, the homeless have many problems with access to income maintenance programs and are less likely than non-homeless people to be receiving such benefits. Despite the stereotype of homeless people passively accepting this fate, the homeless used advocacy services to attack income maintenance problems more often than did the never-homeless.

Over half, 59.9 percent, of the ever-homeless claimed to have used shelters. That 10.6 percent of the never-homeless also claimed to have used shelters is probably due to conflicting definitions of what constitutes a shelter. These 19 respondents had lived at programs which we designate as residential treatment programs.

Surprisingly, 56.5 percent of the currently-homeless and 79.8 percent of the formerly-homeless reported using meal programs (this data not shown). When these two sub-groups are combined into the ever-homeless, 68 percent of the total group have used meal programs, compared to 66.7 percent of the never-homeless. It is surprising that the currently-homeless are the least likely to use meal programs, as one might assume they would have the greatest need for this service. This might occur because many of those in transitional shelters never used such programs and now are served meals at the shelter.

In general, both groups tend to use in-kind services more than therapeutic services. However, the difference between use of in-kind and therapeutic services is greater with the ever-homeless than with never homeless respondents. The percent of never homeless respondents using each service was between 10 and 20 percent for all services except meal programs and material assistance. In contrast, the percent of ever homeless respondents using in-kind services ranged from 31 to 68 percent, while the percent using therapeutic services ranged from 15 to 27 percent for each type of service.

Present Use of Services. Table 5.2 reports current use of service categories. Because current use was being investigated, this section compares those who are currently homeless and those who are not.

Lower levels of service use exist compared to those reported in Table 5.1. This can be attributed in part to the different structure of the questions as well as the difference in the element of time. For past use of different services, respondents were asked if they used each type of service individually. For present use, they were asked to name agencies with which they interacted around the time of the interview.

Several types of agencies appeared which were not individually listed in Table 5.1, such as the Veterans Administration, hospitals, outpatient clinics, and emergency services. With the exception of multi-service agencies, these new categories were reported by very few people. Differences between the homeless and others were not significant for any of these additional services not reported in Table 5.1.

Because of these reporting problems, it is likely that Table 5.2 underreports the level of current service use. Only 140 people, or 26.1 percent of the total sample, said that they were currently using a service. This is surprising in that, by definition, all of the study's respondents

Table 5.2

Present Use of Services[a]

	All (N=140)	Currently Homeless (N=54)	Not Currently Homeless (N=86)
In-Kind Services			
Shelters	10.7%	23.6%	2.5%**
Meal programs	26.9	13.9	35.2**
Drop-in centers	4.6	7.9	2.5
Material assistance	3.6	3.5	3.8
Housing locators	0.6	1.5	-0-
Therapeutic Services			
Alcohol treatment	5.9%	8.8%	4.1%
Counseling	2.3	5.9	-0-*
Drug treatment	1.1	2.9	-0-
Other Services			
Employment	9.6%	11.8%	8.1%
Advocacy (public assistance)	0.6	-0-	.9
Multi-service	21.8	21.2	22.2
Financial assistance (private)[b]	6.1 (529)	9.4 (177)	4.5* (352)
Job training[b]	14.0 (525)	10.2 (176)	15.9 (349)

[a] Figures reported as percentage of those currently using services, which is 29.8% of the currently homeless, 24.2% of those not currently homeless, and 26.1% of the total sample.

[b] From questions elsewhere in interview; figures reported as percentage of total sample.

* $p < .05$
** $p < .01$

Note: Numbers and percents are rounded.

were currently using a service by receiving a free meal. Of those who reported currently using any service, only 26.9 percent said that they were using meal programs. In the Table 5.2, figures given for each listed service represent the proportion of respondents currently using any service at all.

As was true for past service use, respondents were more likely to be using the more tangible services: meal programs, shelters, employment services, and multi-service agencies. In most cases, the homeless use more services than do others. As so few people admitted to using many of the services, however, differences between the currently homeless and all others were generally not statistically significant.

Nonetheless, significant differences exist between the currently-homeless and all others for several service categories. Not surprisingly, the currently homeless were more likely to use shelters. The fact that any of the non-homeless respondents reported currently staying in shelters is again due to definitional problems. The currently-homeless were also more likely to be using counseling services (5.9%) as none of the comparison group was using that service.

As discussed above, the currently homeless report less use of meal programs. Among those reporting service use, they were about one-third as likely to use meal programs as were those not homeless at the time of the interview. Of the non-homeless, 35.2 percent claimed current use of meal programs compared to only 13.9 percent of the currently-homeless.

The homeless were less likely to be currently participating in job training programs, although the differences were not significant. It is likely that most were referring to workfare programs required by the

Illinois Department of Public Aid. The fact that homeless people were less likely to participate is probably a reflection of their lesser likelihood to receive public assistance (mentioned in Chapter 4).

Negative Experiences with Agencies. As mentioned above, one stereotype regarding the homeless is that they fail to take advantage of available services. Another common belief is that encounters between the homeless and various agency personnel are often less than satisfactory. Repulsed by their appearance and body odor, some workers have been accused of ignoring or even ejecting potential clients who are homeless. On the other hand, the homeless are said to be uncooperative, impatient, and irresponsible.

Our findings suggest that a considerable number of people say they had problems with agencies--32.4 percent of all respondents. While it is not known whether these problems occurred during a period of homelessness, the ever-homeless were more likely to have had problems (to a statistically significant degree). Of the ever-homeless, 37.5 percent had such problems compared to 22.7 percent of the never homeless. There were also significant differences between the currently homeless and all others; 40.4 percent of the currently homeless reported having problems, as did 28.4 percent of all others.

Table 5.3 lists the types of services with which people had problems. The numbers shown are a percentage of all persons who had problems, not the total sample. Most of these problems centered around public assistance. Of the respondents having negative experiences with agencies, over half (56.2%) had problems with public assistance programs and agencies. The second largest category was employment services, with which 17.4 percent of such respondents had problems. From open-ended responses, however, we conclude that

Table 5.3

Negative Experiences with Specific Agencies[a]

	All[b] (N=168)	Ever Homeless[b] (N=126)	Never Homeless[b] (N=42)
Respondents having negative experiences with:			
Public Assistance	56.2%	51.3%	70.1%**
In-Kind Services	9.6	12.0	2.6
Therapeutic Services	6.1	8.1	-0-
Employment	17.4	14.8	25.2
Advocacy (with public assistance problems)	-0-	-0-	-0-
Multi-service Agencies	6.3	6.8	4.5
Dept. of Human Services	6.3	7.5	2.6
Other Services	10.1	12.0	4.5

[a] Of those respondents reporting negative experiences with any agency.

[b] Percentages do not total 100% because of multiple responses.

** $p < .01$

Note: Numbers and percents are rounded.

"employment services" were often defined by respondents as including both non-profit agencies who train and place individuals, and day labor agencies.

Of the respondents having problems with agencies, 9.6 percent had problems with various in-kind services (food, shelter, and material assistance agencies), 6.1 percent with therapeutic services, and 6.3 percent with multi-service agencies. The city's Department of Human Services was specifically mentioned by 6.3 percent. No one claimed to have problems with agencies that provide advocacy for income maintenance problems.

Non-homeless respondents were more likely to have had problems with public assistance to a statistically significant degree. This may be partly due to the fact mentioned in Chapter 4 that homeless people tend to receive public assistance less than others. Employment services also caused proportionately more problems for non-homeless than homeless respondents, but these differences were not statistically significant.

The ever-homeless were (proportionate to negative experience) more likely to have had problems than the non-homeless for all other service types: in-kind and therapeutic services, multi-service agencies, the Chicago Department of Human Services, and "other" services. Differences between the two groups were not statistically significant for these types of services.

Attitudes toward Agency Help. A series of questions designed to measure attitudes toward agency help was also included in the interview. Respondents were asked to agree or disagree with the following statements: "Most workers in social service programs do not really help people," "It's usually just not worth my time and effort to get to most programs," "Talking to workers in service programs is too personal," and "I do not need the help that agencies can provide." Responses to these statements provide information on respondents' opinions of the efficacy of various agencies, calculations of time and effort needed to obtain service, willingness to disclose personal information, and willingness to seek help.

Despite the problems discussed above, most respondents seem willing to use various helping programs. As shown in Table 5.4, relatively low percentages of all respondents agreed with these negative statements. Of the total sample, 34.8 percent felt that workers did not really help people, 27.9 percent felt that seeking help was not worth the effort, 26.9 percent were reluctant to disclose personal information, and 21.4 percent did not feel that they needed help.

The greatest amount of dissatisfaction was found in the question about agency or worker efficacy; this finding may support the hypothesis that respondents do not feel agencies provide the services they need. However, when past and present users of services were compared to those having positive and negative opinions of agencies, only minor patterns emerged (see Table B1 in Appendix B). In most cases, those with negative opinions were slightly less likely to use services, either in the past or present. For these opinion variables, none of the differences between service users and non-users were statistically significant. Those with negative opinions were almost equally likely to continue using services.

Although some significant differences have been found between the homeless and others in regard to past and present use of services and negative experiences with agencies, the same cannot be said of attitudes toward agency help; differences are not statistically significant. In general, then, the claim that the homeless are negatively disposed toward help was

Table 5.4

Respondents' Views of Social Services

	All	Ever Homeless	Never Homeless
Percent agreeing with:			
"Most workers in social service programs do not really help people"	34.8% (489)	37.3% (323)	29.9% (165)
"Its usually not worth my time and effort to get to most programs"	27.9 (493)	30.3 (325)	23.4 (169)
"Talking to workers in service programs is too personal"	26.9 (506)	26.3 (335)	28.2 (170)
"I do not need any of the help with problems that agencies can provide"	21.4 (505)	19.7 (332)	24.5 (173)

Differences between groups were not statistically significant at or below .05 level.

Note: Numbers and percents are rounded.

not confirmed--although the fact that our entire sample was at an agency may have constrained this.

Cross-tabulations were also used to test the relationship between service use and attitudes toward agency help for the homeless and non-homeless groups separately. These findings are also reported in Table B1 in Appendix B. For the homeless, negative attitudes toward agency use relate to decreased present use of services in only one case: where respondents do not value services. For the other opinion questions on current use and for all opinion questions pertaining to past use, those with negative opinions tend to use services slightly more often. However, none of the differences between groups were statistically significant. One might guess that homeless people are in such dire straits that they are forced to use services despite having negative feelings about them. For respondents who were not homeless at the time of the interview, the findings are as expected: negative attitudes have a slight relation to reduced service use. As with the homeless, differences between those using and not using services were not statistically significant.

From the combined findings on service use and dissatisfaction reported in this section, one can conclude that the homeless have both relatively high rates of service use, and lesser but still relatively high rates of dissatisfaction with service providers. While there are certainly some homeless individuals who do not avail themselves of any services, it appears that, in general, the homeless have not refused to seek services more than others. Perhaps, at present, the services available are simply not all that useful in helping avoid or escape homelessness.

Work and Income

What might the homeless need? Their clearest problem is income. According to Census Bureau officials, the federal poverty line for a single individual in 1986 is $464.33 per month (or $5,572 per year). As can be seen in Table 5.5, the total mean income reported by all respondents in our sample is quite modest--$257.40 per month. As this amount is barely over half the federal poverty line, one might conclude that the average person in the sample is at risk. Not surprisingly, the currently homeless received a statistically significant smaller amount on average, roughly 60 percent of what non-homeless people receive. Their mean income is $181.90 per month, as opposed to $295.30 for those who were not homeless at the time of the interview. The average income for the homeless is 39 percent of the federal poverty line.

Sources of Income. A majority of survey respondents, 59.9 percent, were receiving public assistance at the time of the interview. As shown in Table 5.5, the average respondent on public assistance received around $220 from various cash programs. This figure does not reflect the cash value of food stamps or medical services.

Survey respondents received income from a variety of sources in addition to public assistance and earnings from work. The most common sources were family and friends, as around 20 percent of the total sample received money from these two sources. Of all respondents, 10.3 percent received income through pensions, disability benefits, or workers' compensation. Smaller proportions of respondents received veterans benefits, unemployment compensation, and money from private charities.

Table 5.5

Sources of Income

	All	Currently Homeless	All Others
Total Income:	$257.40 (524)	$181.90 (175)	$295.30** (349)
Public Assistance:			
% Receiving	59.9% (531)	45.0% (178)	67.4%** (353)
Average Amount Received	$219.94 (291)	$214.57 (73)	$221.73 (219)
Pension, Disability, Workers' Compensation:			
% Receiving	10.3% (524)	3.5% (175)	13.7%** (349)
Average Amount Received	$333.80 (47)	$293.37 (5)	$339.05 (41)
Veterans' Benefits:			
% Receiving	1.3% (523)	0.5% (174)	1.7% (349)
Average Amount Received	$264.50 (6)	$231.00 (1)	$270.03 (5)
Unemployment Compensation:			
% Receiving	3.5% (524)	3.4% (175)	3.6% (349)
Average Amount Received	$340.73 (16)	$327.67 (5)	$347.04 (11)
Family:			
% Receiving	19.5% (523)	18.4% (174)	20.1% (349)
Average Amount Received	$108.28 (90)	$101.80 (26)	$110.93 (64)

(Continued on next page)

Table 5.5--Continued

	All	Currently Homeless	All Others
Friends:			
% Receiving	19.6% (524)	18.7% (175)	20.1% (349)
Average Amount Received	$55.40 (92)	$53.94 (29)	$56.07 (63)
Private Charities:			
% Receiving	4.0% (521)	8.1% (175)	2.5%** (350)
Average Amount Received	$57.86 (19)	$43.93 (13)	$88.72 (6)
Panhandling:			
% Receiving	11.9% (524)	14.1% (175)	10.8% (349)
Average Amount Received	$21.58 (53)	$20.71 (20)	$22.10 (33)
Selling Blood:			
% Receiving	1.7% (524)	3.5% (175)	0.8%** (349)
Average Amount Received	$20.00 (9)	$17.70 (6)	$25.31 (3)

(Continued on next page)

Table 5.5--Continued

	All	Currently Homeless	All Others
Other Sources:			
% Receiving	6.9% (523)	9.8% (175)	5.5% (348)
Average Amount Received	$193.60 (32)	$217.11 (13)	$178.14 (19)
"Hustling":[a]			
% Receiving	13.3% (525)	14.6% (175)	12.7% (350)
Average Amount Received	$298.18 (67)	$541.48 (26)	$148.78* (42)

[a] From questions later in interview.

* $p < .05$
** $p < .01$

Note: Numbers and percents are rounded.

"Panhandling," or asking for money in the streets was reported by 11.9 percent. Only 1.7 percent admitted selling their own blood for money. This is surprising as selling blood is reputed to be a common method for poor people to obtain quick cash. Of the respondents, 6.9 percent said that they had income sources other than the types listed above.

The respondents were also asked if they had used any sort of "hustle" to get money. Although they were not asked specifics about what hustle, it became clear from comments made to interviewers that respondents' definitions of hustling ranged from illegal activities such as prostitution and selling drugs to games of chance (pool, dice, pitching pennies) to occasional and sporadic work such as babysitting or shoveling snow. As shown in Table 5.5, about 13.3 percent of the total sample admitted to hustling in the past month. The mean amount earned from hustling was around $298 per month while the median amount earned was $100.

Currently homeless respondents were less likely to receive income from most of these sources. For pension, disability, and workers' compensation income and for public assistance, statistically significant differences were found. Only 45 percent of the currently homeless received income from public assistance, compared to 67.4 percent of the non-homeless. Non-homeless respondents were about four times more likely to receive benefits from a pension, disability, or workers' compensation program. Most of this difference can be accounted for by the fact that the homeless are much less likely to be receiving Supplemental Security Income (noted in Chapter 4). The currently homeless were also less likely to receive veterans benefits, unemployment compensation, or money from their families and friends. However, these differences were not statistically significant.

The currently homeless were more likely to receive income from several other income categories. They were about three times as likely to receive money from private charities. However, the amounts they received were roughly half of what the non-homeless received from these same agencies ($43.93 versus $88.72). The currently homeless were slightly more likely to engage in panhandling.

The currently homeless were about five times as likely to sell their blood than were non-homeless people. But as this comparison represents only nine individuals, one should be cautious about drawing conclusions. The currently homeless were also more likely to claim income from other miscellaneous sources. Except for these miscellaneous sources, the amounts that the currently homeless received from all sources were on average always somewhat less than those received by non-homeless people.

The currently homeless were only slightly more likely to hustle, but the amounts they earned were more than three and a half times greater than that earned by non-homeless hustlers. The mean amount earned by the homeless is $541.48 per month, while the non-homeless averaged $148.78. Again, one should be cautious about drawing conclusions from these data as relatively few people (sixty-eight) received money from hustling and several individuals in each group reported large earnings.

It thus appears that homeless people have much more difficulty obtaining income from formal sources such as pensions, unemployment compensation, veterans benefits, and disability programs. This phenomenon may be related specifically to their homeless status, or may be caused by other factors which also make homelessness more likely, such as emotional problems. The homeless seem to have more informal and irregular sources of income, as they are more likely to receive money from selling blood, private charity, hustling, and panhandling. These are the places where one turns out of desperation, when regular sources of income have been interrupted.

Work. Some views of the homeless assume that many of the homeless are unwilling to work or are unable to work because of alcoholism and mental illness. The former idea is part of a claim that homeless people have rejected normal societal behaviors and thus have chosen their condition.

As shown in Table 5.6, 32.2 percent of the all respondents in the sample were working at the time of the interview. The homeless and not homeless groups barely differ in the proportion of people working. Given the obvious and considerable barriers which many homeless individuals must overcome in order to work, it is surprising that so many are able to work.

Respondents were asked how many days out of the past month they had spent doing work of four types: day labor, part-time work, full-time work, and occasional work. As shown in Table 5.7, more members of our sample, 13.2 percent, performed daily labor than any other type of work. Occasional work accounted for 10.3 percent, while 7.0 percent were employed full-time, and 5.5 percent were employed part-time.

Other than a large difference between full-time work and other types, the average number of days the respondents spent at these types of work did not vary greatly. Full-time employees averaged 18.8 days per month, while part-time employees averaged 11.6 days, daily laborers 7.9 days, and occasional workers 8.2 days per month. Thus, from the types of work and the number of days worked it appears that the employed members of our sample worked only sporadically.

Table 5.6

Current Work and Income

	All	Currently Homeless	Not Currently Homeless
Percent who are working	32.2% (524)	32.7% (174)	32.0 (350)
Income from work (in dollars)	$243.48 (162)	$142.56 (56)	$296.44** (107)
Percent who are looking for work	39.4% (432)	41.4% (138)	39.3% (294)

** $p < .01$

Note: Numbers and percents are rounded.

Table 5.7

Types of Work

	All	Currently Homeless	All Others
Day Labor:			
Percent working at time of interview	13.2% (525)	17.3% (175)	10.8% (350)
Average number of days per month	7.9 (72)	6.7 (33)	8.9 (39)
Part-Time:			
Percent working at time of interview	5.5% (526)	3.6% (176)	6.6% (350)
Average number of days per month	11.6 (30)	11.4 (7)	11.6 (23)
Full-Time:			
Percent working at time of interview	7.0% (526)	4.7% (176)	8.4% (350)
Average number of days per month	18.8 (36)	17.3 (7)	19.1 (29)
Occasional:			
Percent working at time of interview	10.3 (524)	11.5% (176)	9.7% (348)
Average number of days per month	8.2 (56)	5.3 (22)	10.1* (34)
Other Work:			
Percent working at time of interview	1.5% (526)	1.6% (176)	1.5% (350)
Average number of days per month	6.9 (9)	5.7 (3)	7.6 (5)

* $p < .05$

Note: Numbers and percents are rounded.

As reported in Table 5.7, the homeless were slightly more likely to be performing day labor and occasional work, but on average, worked fewer days. They were about half as likely as the non-homeless to work full-time. The homeless were also less likely to work part-time than the non-homeless, but the number of days worked was roughly the same.

On average, working members of the sample earned $243.48 per month (reported in Table 5.6). The two groups do differ in the amount of money earned, with the currently homeless receiving less than half of what non-homeless people earn per month. Working persons who were currently homeless received an average monthly income of $142.56 while those who were not currently homeless received an average of $296.44. Thus, while the homeless are no less likely to work than other very poor people, they work less days, at more sporadic types of work, and earn less money.

Although 32.2 percent of all respondents were working at the time of the interview, almost all (93.9%) had worked in the past. Of those who have worked in the past and were unemployed at the time of the interview, there was an average of 4.4 years since their last job.

To better understand the relationship between homelessness and work, we developed cross-tabulations (not reported in the tables) to explore characteristics of those who were employed at the time of the interview. Surprisingly, most of these factors, such as race, history of mental hospitalizations, problems with alcohol, current or past homelessness, and current marital status, did not prove to be related to whether one is currently working or not. The three variables that were associated with employment to a statistically significant degree were age, sex, and education--those who were working were more likely to be male, younger, and to have more years of schooling.

Finally, out of the total sample, 39.4 percent said that they were looking for work. Of the currently homeless, 41.4 percent and 39.3 percent of all others said they were actively seeking employment.

Debts. While most people would agree that the homeless suffer from a severe lack of financial resources, the role of insufficient income in causing homelessness has not been fully explored. In an attempt to assess the respondents' financial conditions, they were asked about various types of debts that they may have had at the time of the interview. Amounts assigned to the different categories of debt were also summed for each individual. As shown in Table 5.8, 29.6 percent of the total sample had some form of debt. The mean amount of debt was $1,308.12, but the median amount of debt was $337.50. Approximately 25 percent of all respondents with debts owed more than $1,000 and two individuals owed more than $10,000. Substantial proportions of the total sample owed money for three types of debt: 12.8 percent of all respondents owed back rent, 14.3 percent owed for utility bills, and 10.4 percent owed "other" debts. On average, $341.21 was owed for back rent, $295.69 for utility bills, and $1,934.14 for other debts.

Relatively few people in the total sample owed money on the remaining types of debts, including mortgage payments, taxes, and consumer debts (including charge cards, bank loans, etc.). The average amounts owed in these three categories tended to be large: $2,019.50 for mortgage payments, $1,748.33 for consumer debts, and $824.31 for taxes. However, as relatively few people reported these types of debts, the averages are likely to be

Table 5.8

Average Debts

	All	Currently Homeless	All Others
Total Debts:			
Percent Owing	29.6% (536)	29.1% (181)	29.9% (355)
Average Debt	$1,308.12 (159)	$1,566.39 (53)	$1,179.62 (106)
Type of Debt:			
Back Rent:			
Percent Owing	12.8% (518)	15.3% (169)	11.4% (349)
Average Debt	$341.21 (64)	$523.07 (24)	$232.78* (40)
Mortgage Payments:			
Percent Owing	1.5% (524)	1.1% (174)	1.8% (350)
Average Debt	$2,019.50 (9)	$2,700.00 (2)	$1,792.67 (6)
Utility Bills:			
Percent Owing	14.3% (514)	13.8% (167)	14.5% (347)
Average Debt	$295.69 (72)	$234.68 (21)	$320.61 (51)
Back Taxes:			
Percent Owing	1.3% (520)	2.1% (174)	0.9% (347)
Average Debt	$824.31 (7)	$947.81 (3)	$691.67 (3)

(Continued on next page)

Table 5.8--Continued

	All	Currently Homeless	All Others
Consumer Debts:			
Percent Owing	4.2% (521)	4.8% (173)	3.9% (348)
Average Debt	$1,748.33 (22)	$788.08 (7)	$2,259.92 (14)
Others:			
Percent Owing	10.4% (522)	12.7% (174)	9.0% (349)
Average Debt	$1,934.14 (54)	$2,314.82 (22)	$1,676.71 (32)

* $p < .05$

Note: Numbers and percents are rounded.

greatly affected by a few individuals owing large sums. Four of the nine persons behind on their mortgages owed more than $1,000. Two persons out of the seven owing back taxes owed $1,000 or more, and eight of the 22 who had consumer debts owed more than $1,000.

The homeless and domiciled groups did not vary significantly on the issue of indebtedness overall: 29.1 percent of the homeless had debts, compared to 29.9 percent of the non-homeless. The mean amount owed by homeless respondents was $1,566.39, while the median amount was $477.00. For the non-homeless, $1,179.62 was the mean and $250.00 the median amount.

Currently homeless respondents were slightly more likely to owe for back rent, but owed much larger amounts: 15.3 percent of the currently homeless owed back rent, compared to 11.4 percent of the non-homeless. However, the currently homeless owed more than twice as much as non-homeless individuals for back rent--$523.07 on average, compared to an average of $232.78 for non-homeless individuals. Such rent debts probably caused eviction.

Homeless and non-homeless respondents were about equally likely to owe money on utility bills, 13.8 percent of the homeless and 14.5 percent of the non-homeless. However, the non-homeless owed more: an average of $320.61 compared to $234.68 owed by the average homeless respondent. It should not be surprising that the two groups differ, given that domiciled individuals are continuing to incur debt on utility bills, while the homeless do not. However, these findings do not support the claims made by some that large numbers of people are being pushed into homelessness by high utility bills and other debts.

The currently homeless were slightly more likely to owe for debts separate from the five categories listed. The percentage of the homeless who owed such debts is 12.7, as compared to 9.0 percent of the non-homeless. The average amounts owed by the two groups differed: the homeless owed an average of $2,314.82 while the non-homeless owed $1,676.71, on average. While it is difficult to draw conclusions without knowing more about these debts, it is possible that these "other" debts are owed to family members or friends. If so, they may also be a factor in causing evictions as individuals or families decide they can no longer afford to help out a needy friend or relative.

Social Network

Another common claim is that the homeless lack intangible resources, such as friendships or even correct "attitudes." A good deal of information about the social networks of the homeless in particular has appeared over the last few years. Much of this information suggests that the homeless are unusually isolated. Not only are they individuals who often live alone or with few supports, but they allegedly have few friends or relatives to help with day-to-day problems. Compared to the general population, rather large numbers of the homeless are said to have no friends or relatives (Bassuk, Rubin, and Lauriat, 1984; Rossi _et_ _al_., 1986; Roth _et_ _al_., 1985). However, it is not yet clear whether this alienation from family and friends is unique among the homeless. This lack of contacts may be true of most of those who are very poor, and might perhaps be a consequence of this general state; lack of contacts may be a result of homelessness; or, a lack of contacts may somehow contribute to homelessness.

The survey thus included questions about the respondents' social networks. Individuals were first asked to list the individuals who were important parts of their lives, and with whom they had some contact within the last thirty days. Upon supplying first names, the respondents were then asked to identify the individuals as family members, domiciled friends, or--for those who have been homeless at some point in time--friends who are homeless. For each of the three groups, respondents were then asked whether they received shelter, food, cash, or information from that component of the social network during the last thirty days.

Family and Relatives. Table 5.9 presents the replies to questions about family. Responses from the entire sample are reported, as are those of the currently homeless compared to the domiciled. In general, the results confirm that contacts with a family network are somewhat limited, at least for a large minority of the sample.

The average number of important relatives seen over the last 30 days was 3.4. This appears to be a somewhat low number of contacts. In addition, 18 percent of the sample listed no contacts at all. This probably is a high level of isolation compared to the general population. Roth *et al.*, (1985) reports that 92.4 percent of the rural adult population in Ohio say that they have some relative on which they can rely. Nevertheless, the vast majority of the sample has at least some such contact.

Fair, but not enormous, proportions receive some sort of support from relatives. About 42 percent of the sample received a meal, 37 percent received cash, 28 percent received shelter, and 16 percent received information.

Table 5.9

Contacts with Family and Relatives

	All	Currently Homeless	All Others
Percent seeing no relatives	18.0% (520)	34.1% (173)	10.1%** (348)
Average number of relatives seen in past 30 days	3.4 (520)	2.2 (173)	4.0** (348)
Percent receiving shelter from relatives	27.6% (505)	20.0% (173)	33.5%** (332)
Percent receiving food	41.8% (503)	33.9% (169)	45.8%** (334)
Percent receiving cash	37.0% (504)	32.5% (169)	39.3% (335)
Percent receiving information	15.8% (503)	12.7% (169)	17.4% (334)

** $p < .01$

Note: Numbers and percents are rounded.

Comparing groups, the homeless seem to have smaller social networks than do those who are not currently homeless. To a statistically significant degree, the homeless list fewer relatives than do those who have a place to stay at present. The typical homeless individual lists only 2.2 relatives, while a rather high 34 percent claims to have no such relatives in the social network at all.

The homeless are also somewhat less likely to receive shelter from relatives, or food from relatives. Perhaps surprisingly, differences in the receipt of cash and information are small and not statistically significant.

Despite these differences, it appears that other studies have overestimated the lack of contacts with relatives. It is perhaps surprising to find that the vast majority of the homeless--66 percent--claim to have some contact with relatives. This is a large figure, given the vast difficulties in retaining ties without an address, a telephone, and cash for travel and visiting. Further, the differences between the homeless and those who are domiciled are probably not as great as they might at first appear. As has been noted, the homeless are less likely than those who have a place to stay to consider a spouse or other relatives as part of their household. For example, only about 2 percent of the homeless consider a relative other than a spouse or children as part of their household, compared to nearly 26 percent of those who are domiciled.

We suspect that the major differences in the network do not involve visiting, contacts, or sharing among individuals with whom one does not live, but rather reflect differences in the composition of the current household. To test this, the same variables as above were analyzed, but removing those respondents who live with relatives. These findings are reported in Table 5.10.

Differences between the two groups remained significant for the level of overall contacts, but seem to be smaller. However, the differences between the two groups for the receipt of shelter and food from relatives were greatly reduced and were no longer statistically significant. In general, it seems that differences in contacts with relatives between the currently homeless and others may be partly, but not totally, due more to the fact that the non-homeless are more likely to live with family and relatives.

If anything, it is surprising that so many homeless individuals manage to continue such contacts. We must conclude that the claim that relatives have completely abandoned those who become homeless is greatly exaggerated. A fair proportion have shared a meal, received cash, or even received temporary shelter from their relatives within the last thirty days; the vast majority have continued at least one contact.

Friends. Respondents were also asked about contacts with friends who have a place to stay. If they had been homeless, the respondents were also asked about their contacts with homeless friends. Table 5.11 reports findings for contacts with domiciled friends.

The picture of limited contacts is even more clear with respect to domiciled friends than it is with respect to relatives. The typical number of friends listed by the sample members is less than two; over one-third of the sample reports no such friends, at all. A fair proportion, nearly 39 percent, has received food from friends; receipt of cash, shelter, or information is in the 20 percent range.

Table 5.10

Contacts with Relatives for Respondents Not Living with Relatives

	All	Currently Homeless	Not Currently Homeless
Percent seeing no relatives	22.2% (398)	34.5% (160)	13.8%** (238)
Average number of relatives seen in past 30 days	3.1 (398)	2.3 (160)	3.7** (238)
Percent receiving shelter from relatives	16.2% (391)	14.8% (161)	17.2% (230)
Percent receiving food from relatives	34.2% (383)	33.2% (157)	34.9% (226)
Percent receiving cash from relatives	30.2% (384)	31.9% (157)	29.0% (227)
Percent receiving information from relatives	13.4% (384)	13.0% (157)	13.8% (227)

** $p < .01$

Note: Numbers and percents are rounded.

Table 5.11

Contacts with Domiciled Friends

	All	Currently Homeless	All Others
Percent seeing no domiciled friends	35.1% (521)	49.9% (173)	27.8%** (349)
Average number of domiciled friends	1.9 (521)	1.3 (173)	2.3** (349)
Percent receiving shelter from domiciled friends	22.8% (498)	21.0% (170)	23.8% (327)
Percent receiving food	38.8% (499)	30.3% (169)	43.1%** (330)
Percent receiving cash	26.5% (497)	21.9% (167)	22.9% (330)
Percent receiving information	20.6% (496)	19.5% (167)	21.2% (329)

** p < .01

Note: Numbers and percents are rounded.

There are a few differences between the homeless and those who do have homes in this respect. Whether it is preference or an inability to keep contacts alive while homeless, the homeless report fewer domiciled friends--only 1.3 on average, compared to 2.3 for those who are not homeless. Nearly half of the homeless report seeing no domiciled friends, at all. And while differences involving the receipt of information, cash, or shelter are small, the homeless are less likely to share a meal with friends. However, Table 5.11 only includes contacts with domiciled friends and thus may underestimate the actual amount of contacts with friends for those respondents who are homeless. Table 5.12 thus reports on contacts between respondents who have been homeless and their homeless friends. But even from these findings, the homeless would appear to be severely isolated on the streets. The typical homeless individual reports less than one homeless friend; two thirds report no such friends.

At the same time, reports of sharing among the homeless are limited. Those who are, or have been homeless, relatively rarely report sharing food, cash, or information with one another. While the formerly homeless, on average, saw fewer homeless friends and were more likely to not have homeless friends, these differences were not statistically significant. A fair number seem to continue such contacts, which might show how close to being homeless they are.

Other studies of the homeless have not asked specifically about contacts with homeless friends and thus have found differences between the homeless and non-homeless similar to those reported in Table 5.11. However, if one adds contacts with homeless friends to the totals for domiciled friends, differences between the homeless and non-homeless are greatly

Table 5.12

Contacts with Homeless Friends[a]

	All	Currently Homeless	All Others
Percent seeing no homeless friends	73.0% (337)	67.8% (168)	78.3% (169)
Average number of homeless friends	0.6 (337)	0.8 (168)	0.4 (169)
Percent receiving food from homeless friends	14.2% (284)	16.6% (151)	11.6% (133)
Percent receiving cash	14.9% (286)	18.2% (152)	11.1% (135)
Percent receiving information	22.8% (286)	21.8% (152)	23.8% (135)

[a] Asked only of respondents who had ever been homeless.

Differences between groups were not statistically significant at or below .05 level.

Note: Numbers and percents are rounded.

reduced (that is, even when the continuing contacts of the formerly homeless with homeless friends are considered). As reported in Table 5.13, the number of friends listed by the homeless increases to 2.0, while for those who are not homeless--half of whom have a history of homelessness and thus are likely to have homeless friends--the total number of friends rises to 2.5. While the differences between the two groups for domiciled friends (reported in Table 5.11) were statistically significant, they are not when one considers all friends. Those receiving food or sharing a meal among the currently homeless increase to 37.5 percent, compared to 45.2 percent for those who are not homeless. The differences between the two groups do not remain statistically significant.

In sum, while isolation from friends is indeed common among the homeless and among many other members of the sample, the homeless are much like the other very poor individuals in the sample in this respect.

Transience. The homeless are often viewed as being comprised mostly of transients--people who move from place to place in search of jobs or for other reasons. This characteristic was emphasized in studies of homeless populations prior to this decade, even as a cause of homelessness--although studies conducted since 1980 have generally tried to refute this view.

According to U.S. Census statistics, roughly 16 percent of all Americans move every year (U.S. Bureau of the Census, 1984). Our sample is very similar: 17.4 percent of our sample moved in the year prior to being interviewed. The ever-homeless and never-homeless differed slightly on this measure: 19.1 percent of the ever-homeless had moved in the past year, compared to 12.1 percent of the comparison group. These differences were not statistically significant.

Table 5.13

Combined Contacts with Domiciled and Homeless Friends

	All	Currently Homeless	All Others
Percent seeing no friends	29.2% (521)	34.6% (173)	26.2% (349)
Average number of friends	2.3 (521)	2.0 (173)	2.5 (349)
Percent receiving food from all friends	42.5% (502)	37.5% (171)	45.2% (331)
Percent receiving cash	31.4% (505)	32.3% (171)	30.9% (334)
Percent receiving information	27.1% (504)	30.3% (171)	25.5% (333)

Differences between groups were not statistically significant at or below .05 level.

Note: Numbers and percents are rounded.

As stated above, many studies have found that a majority of the homeless were long-term residents of the city where they were interviewed (Crystal *et al*., 1982; Stevens *et al*., 1983; Rossi *et al*., 1986). This also proved to be true for persons interviewed in our study: 55.6 percent of the total sample claimed to have always lived in Chicago. Of those who had ever been homeless, 48.7 percent had always been in Chicago, as compared with 68.8 percent of the never-homeless. The difference between these two groups was statistically significant, however.

For those who have not lived in Chicago all their lives, the amount of time since they moved here ranged from 2 days to 60 years, with an average of 13.6 years. The ever-homeless had, on average, moved to Chicago more recently than the never-homeless, but differences were not statistically significant. Non-natives of Chicago who had ever been homeless moved to Chicago an average of 12.7 years ago while those who had never been homeless arrived 16.4 years ago, on average. Again, while the homeless were more likely to be newer to the city, there is not evidence of a great deal of transience.

There is also evidence, at least from this survey, that homelessness is largely experienced by those born in the United States. Only 4.4 percent of the total sample, 24 people, had been born outside of the United States: 14 respondents were born in Mexico, three were Cubans, two came from Canada, two from Europe and one respondent each was born in Puerto Rico, Africa, and another Caribbean country. The relative lack of foreign-born respondents may be due to rules requiring immigrants to have a support system to assist if financial difficulties occur. On the other hand, immigrants who experience economic hardships may not turn to the meal programs, shelters, and other locations where interviewing took place.

Street Culture. Much of the writing on homelessness up until the late 1970s viewed the homeless as a subculture with a unique lifestyle and set of values. A loose sense of cohesiveness and an irregular but often effective communication network was said to exist within this group. Researchers of this era often focused on certain characteristics of the homeless--the extent of alcoholism, alienation from traditional family systems and other social institutions. While it would be foolish to claim that this phenomenon has disappeared entirely from the urban scene, there remains the question--are some of the characteristics associated with "street people", such as alienation, true of most homeless people? To what extent can this contribute to homelessness?

Survey respondents were asked a number of questions which reveal their attitudes about life on the street. Ultimately, their responses can be used to judge the amount of identification they have with a "street person" subculture. All respondents were asked whether they agree with the statement, "I like going where I want and sleeping where I want." As shown in Table 5.14, the currently homeless were slightly less likely to agree with that statement, although the differences between the currently homeless and all others were not statistically significant. Interviewers noted that many respondents reacted strangely to this question and it is not clear if what is being measured is one's identification with a street culture or one's feelings of independence, regardless of whether one is domiciled.

Respondents who had experienced homelessness at any point in their lives were asked to agree or disagree with a series of statements about life

Table 5.14

Perceptions of Life on the Streets

Percent Agreeing with Statements:	All	Currently Homeless	All Others
"I like being where I want and sleeping where I want"[a]	74.6% (512)	72.7% (169)	75.6% (343)
"I feel like I have a lot in common with other people who don't have homes"[b]	57.9% (386)	53.9% (167)	61.0% (219)
"Street people are easy to get along with"[b]	43.4% (277)	38.4% (141)	48.5% (136)
"People look at you funny when you don't have a permanent home"[b]	86.0% (278)	86.4% (146)	85.7% (132)
"Its easy to get things to eat and drink on the streets"[b]	31.9% (275)	31.4% (140)	32.4% (134)
"It is dangerous to live on the streets"[b]	90.6% (288)	91.3% (151)	89.9% (136)
It is hard to find a place to sleep on the streets"[b]	82.6% (279)	84.5% (144)	80.7% (135)

[a] Asked of all respondents.

[b] Asked only of respondents who had been homeless.

Differences between groups were not statistically significant at or below .05 level.

Note: Numbers and percents are rounded.

on the streets. Of particular interest are the high percentages of persons who agreed with the statements, "It is dangerous to live on the streets" (90.6% of the total sample) and "It is hard to find a place to sleep on the streets" (82.6% of all respondents).

The currently homeless were less likely than ex-homeless to agree with the statements "I feel like I have a lot in common with other people who don't have homes," "Street people are easy to get along with," and "Its easy to get things to eat and drink on the streets." The currently homeless were more likely to agree with the statements: "People look at you funny when you don't have a permanent home," "It is dangerous to live on the streets," and "It is hard to find a place to sleep on the streets." None of the differences between the currently homeless and the ex-homeless on these questions proved to be statistically significant.

Surprisingly, responses to these questions indicate a currently homeless group which seems less accepting or less comfortable with that condition than do many who have been homeless in the past but who are no longer homeless. Particularly revealing is the fact that only 53.9 percent of the currently homeless felt that they had a lot in common with other homeless people, while 61.0 percent of the previously homeless felt that way. From the responses to the above six statements, it appears that the currently homeless are less identified with a "street person" sub-culture.

Thus, it seems unlikely that having such attitudes causes individuals to remain homeless or to be homeless at any given point. Some of the currently homeless do seem to identify with street culture. However, if such attitudes were really a causal factor, one would expect the scores on these factors to be higher for the currently homeless than for those who were homeless in the past. It appears that identification with street culture may reflect being homeless but does not seem to cause individuals to refuse to seek a place to stay.

Problems in Daily Living

In sum, how do the homeless live? Previous studies have suggested that daily existence is indeed very difficult for the homeless. This section will examine various factors to determine if the other very poor people in our sample experience similar problems.

Nutrition. Despite the growth of meal programs, meeting minimal nutritional needs appears to be a significant problem for a majority of the people sampled in this study. As seen in Table 5.15, respondents stated that they were not able to get enough to eat 31.3 percent of the time. Although one might assume that the homeless would be more likely to have problems obtaining sufficient nourishment, differences between the homeless and non-homeless were not significant.

One might also wonder if these figures were affected by a minority of persons having great difficulty obtaining food. This was not the case. Out of the total sample, only 29.4 percent said they never had problems obtaining enough to eat. Again, statistically significant differences did not exist between the currently homeless and other groups.

Safety. Personal safety also appears to be a significant problem for survey respondents, whether they are homeless or not. As reported in Table 5.15, all respondents reported not feeling safe 41.9 percent of the time. Surprisingly, those who were not homeless at the time of the interview were slightly more likely to not feel safe, although differences were

Table 5.15

Average Percentage of Time that Daily Problems Are Experienced

	All	Currently Homeless	Not Currently Homeless
Not having enough to eat	31.3% (522)	32.4% (174)	30.7% (348)
Not feeling safe	41.9% (522)	40.2% (175)	42.8% (348)
Not being able to get needed medical help	27.7% (519)	26.7% (174)	28.2% (346)
Not being able to get shelter when needed[a]	NA	32.7% (134)	NA

[a] Only asked of the currently homeless.

Differences between groups were not statistically significant at or below .05 level.

Note: Numbers and percents are rounded.

not statistically significant. As with the previous section on nutrition, one might wonder about the effect of extreme views expressed by a minority of respondents. 29.8 percent of the total sample said that they always felt safe, while 17.1 percent said that they never felt safe. The currently homeless were slightly less likely to never feel safe (16.3% versus 17.5% for those not currently homeless) and slightly more likely to always feel safe (30.0% versus 29.6% for those not currently homeless). Differences between these groups were not statistically significant on either measure.

Access to Medical Care. Despite the lack of many targeted services, getting medical care when it was needed seemed to be less of a problem for survey respondents than nutrition or safety. Table 5.15 shows that respondents say they were unable to get medical care 27.7 percent of the time when they needed it. Currently homeless respondents reported being unable to get needed medical care 26.7 percent of the time and those not currently homeless 28.2 percent. While differences between the two groups were not statistically significant, it is interesting that the homeless did not show more evidence of having problems accessing health care.

However, the currently homeless are significantly more likely to say that they have no problems getting medical help when they need it: 59.8 percent of the currently homeless versus 49.2 percent of those not currently homeless claimed to have no problems accessing health care. The currently homeless were slightly more likely to say that they always had problems: 11.1 percent versus 9.7 percent for those not currently homeless.

Shelter. Survey respondents who were homeless at the time of the interview were asked how often they had problems finding shelter. Despite the growth in the number of shelters, problems apparently remain. As shown in Table 5.15, homeless respondents said they had problems finding shelter 32.7 percent of the time. Another 43.3 percent said that they had no problems while 7.8 percent said they had problems all the time.

Respondents were then asked where they generally went when they needed a place to sleep indoors. Emergency shelters were by far the most frequently used resource as 73.1 percent said they would go there. Another resource is friends: 11.2 percent said they would go to a friend's place. Other responses include hotels (7.5%), families (5.7%), jail (1.6%), and alcohol detoxification or mental health facilities (0.8%).

Psychological Characteristics Survey respondents were asked a series of questions designed to measure self-esteem, depression, and feeling of control over their lives. The esteem and depression measures were each three-point scales developed by adding the responses to two "yes" or "no" questions. The control measure was a similar four-point scale, with 0 indicating a belief in external control and 3 indicating internal control over one's life.[1] As reported in Table 5.16, the total sample scored 1.2 on the esteem scale, 0.6 on depression, and 2.1 on control.

Surprisingly, those who were currently homeless were slightly more likely to feel in control of their situation than were the non-homeless at the time of the interview. Those who were currently homeless on average scored 2.1 on the control scale while all others scored 2.0, on average. Although the difference between the two groups was not statistically

---

[1] Respondents were asked to agree or disagree with the following statements: "Many of the unhappy things in peoples lives are due to bad luck more than to mistakes the people make." "If I make a plan, I am almost sure I can make it work." "In the long run, the bad things that happen to us are balanced by the good things."

Table 5.16

Psychological Characteristics

	All	Currently Homeless	Not Currently Homeless
Average Scores on Scales for:			
Depression[a]	0.6 (522)	0.9 (174)	0.5** (348)
Control (external versus internal)[b]	2.1 (521)	2.1 (174)	2.0 (347)
Self-esteem[c]	1.2 (523)	1.1 (174)	1.3** (349)

[a] 3-point scale: 0 represents no symptoms of depression and 2 indicates stronger symptomatology.

[b] 4-point scale: 0 represents external control and 3 indicates internal control.

[c] 3-point scale: 0 represents lower self-esteem and 2 reflects a higher esteem level.

** $p < .01$

Note: Numbers and percents are rounded.

significant, one might expect that the homeless would feel less in control of their lives and more at the mercy of various external forces. It may be, however, that many homeless have learned to operate within the limits of this lifestyle and thus are able to retain a sense of control.

Statistically significant differences between the currently homeless and others in the sample did exist on the other two measures. The currently homeless were about twice as high on the scale of depression: their scores averaged 0.9 while the average score for the non-homeless was 0.5. The currently homeless also had lower self-esteem. Their scores averaged 1.1 while the scores for currently domiciled respondents averaged 1.3. These findings present evidence that homelessness does often lead to depression and lowered self-esteem.

Types of Homeless Respondents. Roughly 40 percent of the currently homeless in our sample are clients of transitional shelters. The remaining 60 percent may be staying in overnight shelters, abandoned buildings, in public places, or temporarily with friends or relatives. But the first part of the chapter argued that transitional shelters are more service-intensive. Does this make a difference in day-to-day life?

Table 5.17 presents a comparison of transitional shelter clients and all other currently homeless respondents on several measures presented earlier in this chapter. As expected, there are significant gender differences between the two groups, with transitional shelter clients being 84.3 percent women and other currently homeless persons being 94.1 percent men. There are also smaller but still significant race differences. Over three-fourths, 75.5 percent, of the transitional shelter clients are black, compared to 54.4 percent for other homeless respondents.

Table 5.17

Comparison of Transitional Shelter Clients and Other Currently Homeless Respondents on Demographic Characteristics and Daily Problems

	All	Transitional Shelter Clients	Other Currently Homeless Persons
Percent Male	63.2% (178)	15.7% (70)	94.1%** (108)
Percent Black	65.5% (175)	75.5% (69)	54.4%** (107)
Not having enough to eat[a]	32.4% (174)	23.3% (67)	38.0%** (107)
Not feeling safe[a]	40.2% (175)	31.7% (68)	45.6%** (107)
Not being able to get needed medical help[a]	26.7% (174)	18.5% (68)	31.9%* (106)
Not being able to get shelter when needed[a]	32.7% (134)	21.9% (59)	41.3%** (75)

[a] Figures represent the average proportion of time that all respondents in that category say they had problems.

* $p < .05$

** $p < .01$

Note: Numbers and percents are rounded.

Transitional shelter clients seem to have fewer problems with daily survival. They were much less likely to report difficulty with getting enough to eat, feeling safe, being able to get needed medical help, and being able to get shelter when needed. These differences between the transitional shelter residents and all other homeless respondents were statistically significant.

CONCLUSION

Studies of the homeless prior to the 1980s suggest that people were more likely to become homeless because of alienation from others and because of identification with a street culture. In this study we have found only limited evidence of the impact of these factors.

The homeless do have fewer contacts with friends and relatives than the other very poor people in our sample. But these differences are modest when living arrangements are taken into account and when contacts with homeless friends are also included. A set of values generally described as a "street culture" may exist. However, our data does not provide evidence that such values independently promote homelessness. Tangible factors such as a lack of income from welfare or employment seem to be more strongly related to the likelihood of becoming homeless.

The 1980s have seen a considerable expansion of services designed to meet basic needs. Despite this increase, there are still some problems--perhaps because, as the first two chapters noted, the need for such basic services has expanded so rapidly. General social services seem not to have met these new levels of demand; more likely, they have probably decreased.

As we cannot look at service use precisely from the agency side, we do not know if more homeless people are requesting services. However, we do know that the homeless are more likely than others to use most services. This finding contradicts the common view that the homeless generally are unwilling to use services.

In examining the role of services in combatting homelessness, it is clear that the entire sample suffers from day-to-day problems. Many people lack food, shelter, and medical care. This is particularly true of single homeless adults who cannot use transitional shelters; this group reports that they are unable to find shelter more than 40 percent of the time.

The high incidence of service-use among the homeless suggests that most present services do not help individuals avoid or reverse homelessness. This may be due to problems in service delivery, plus a lack of appropriate tangible services. While services alone may not reverse homelessness, they can ameliorate the conditions suffered by the homeless and, for some, compensate for the lack of support from relatives and others.

There remains much which is not known about the potential contribution of services in combatting homelessness. As the homeless appear to have particular problems obtaining what they need from services, new service models will need to be developed to more effectively reach this population. This suggestion will be further explored in the concluding chapter.

Chapter 6

Some Further Analyses

The information from the survey presents a wide range of statistical comparisons among groups with different homeless experiences, personal traits, and contacts with social service systems. Some of the uncovered relations--such as between homelessness and the timing of admission to a mental hospital--are very specific to small groups within the sample. Others, however, such as the relation of household characteristics to homelessness, are much more general.

The specific relations often involve small numbers of cases or very complex arguments that cannot be taken further in this report. However, some of the general relations deserve a somewhat more sophisticated treatment. The basic issue is that some of the relations that have been uncovered may be linked to each other, so that conclusions that seem apparent may be misleading. For example, blacks and whites apparently differ in homelessness. But this relation may have several causes. Differences among the races in family ties or part-time employment used to avoid homelessness may be involved. A set of equations that simultaneously includes more variables can help to sort out such possibilities--and in so doing, further assess the relative role of economic difficulties, pathologies, and alienation.

This chapter is primarily devoted to developing the more general, multivariate analyses of homelessness. It also provides further information about one key variable that emerges, that is, residing in a one-person household. Finally, it assesses whether one can develop differences among "types" of homeless individuals.

LOGISTIC REGRESSIONS

Unfortunately, even a preliminary attempt to sort out the relations demands complex analysis which some readers may wish to skip and instead proceed to the conclusions. For those who will follow, note that our starting point is that much of the analyses of this report focus on two sets of comparisons. We compare those who have ever been homeless with the never homeless, as well as those who are currently homeless with those who are currently domiciled. Each comparison represents a simple choice of two states.

To analyze the contribution of a list of variables to being in one state or another, we turn to what are called logistic regressions.[1] The procedure estimates equations linking the two measures of homelessness simultaneously to each of a group of explanatory factors (such as alcohol use). We thus test whether each of a group of variables helps "explain" whether an individual is homeless (or, in other equations, whether he or she has ever been homeless) when all are included. Also of interest is whether each such variable increases (a "positive relation") or reduces (a "negative relation") the probability of homelessness if one is very poor. We also look at whether an entire subgroup of variables helps to predict homelessness. For example, we can test whether all our measures of household characteristics (living alone, with children, with relatives, and so forth) combined explain the probability of homelessness. (The size of coefficients, "beta," indicate the "strength" of the relation to homelessness, but will not be discussed in much detail here.)

---

[1] Logistic regressions are used to analyze a choice between two states, because, for various statistical reasons, one cannot simply use a standard regression. For this analysis the dependent variable (that is, homelessness) is transformed into a ratio of the probability that all individuals have the trait, divided by one minus this probability. The log of this statistical function is taken. This ration is calculated for each combination of independent variables (such as high or low mental health, living alone or with others), and it is determined how the ratio varies across the various categories of each of the independent variables, using a mathematical method called maximum likelihood estimation.

Finally, this method allows us to look at the problem mentioned in the introduction. Thus, suppose blacks are less likely to be homeless because they live more often with relatives when they are very poor. If this is the case, when a variable representing blacks and one representing living with relatives are placed in one equation predicting who is homeless, only the relation involving living with relatives will still continue to be noted (we use a criteria of statistical significance). We will point out a few key instances of this type of finding.

One caution is that the statistical tests, like the majority of this document, compare individuals who are in our sample of the very poor. We are not simply discovering whether a given trait is linked to homelessness, but whether a trait is more common among the homeless than among other very poor individuals who were sampled. The distinction is important. For example, in some equations women are more likely to be homeless and blacks are less likely to be homeless than others in the sample. But compared to the population of Chicago, blacks and men are more likely to be homeless. The equation simply indicates that among the very poor in our sample (who are frequently black and male) those few who are not black and are female are more likely to be homeless than they are to be very poor yet not homeless (according to a few of the equations).[2]

Determinants of Ever Being Homeless

Homelessness occurs periodically to individuals, and we have noted that a number of factors might help explain this. Earlier chapters suggested that the lifetime ability to work and other such measures did not separate the ever homeless from other poor individuals. Rather, the homeless could not rely on family as much, and also may have had unusual backgrounds, such as childhood out-of-home care. Finally, alcoholism and mental illness might reduce the ability to cope with problems.

---

[2] In the current case, the determination of which variables to add into the equation, and in which blocks, is crucial. To speak to the first issue, variables included in the equation involve basic demographics that are necessary controls, variables representing factors about which there is much controversy among policymakers, and some variables that have already demonstrated statistically significant relations to homelessness (according to earlier chapters). When more than one, similar variable demonstrated a statistically significant relation to a dependent variable, only one measure is used here; otherwise, the effects of the similar variables would be statistically confused. Only variables that involve a reasonable number of cases are included--for example, there are so few intact families as to make the use of this variable suspect.

To speak to the second issue, the order of entry of blocks is meant to include in each block variables that might have been temporally simultaneous. For example, background variables, such as demographic variables, are added first, followed by work history and institutional history variables, followed by current household characteristics. One object is to determine if the later variables indeed affect the dependent variables after first taking into account characteristics that were entered earlier on. A second is to determine if variables added later eliminate the contributions of variables added earlier.

Such causal orderings require some judgments about what might be simultaneous, and this is one limit to the analysis. In addition, there are some variables, such as mental health status, that might be an effect but not a cause of homelessness status. We include some such variables in some equations, but only with the caution to the reader that, if such variables indeed are effects and not causes, they should not be so included.

The results in Table 6.1--particularly in the last column in which the largest group of variables is considered--suggest that the household variables are particularly important. That is, those who have been homeless are more likely to be single heads of families, who have fewer to turn to in crisis. The same can be said for those who consider themselves to be a one-person household. The homeless are also less likely to live in a household that includes relatives other than a spouse or children. Otherwise, binge drinkers may be homeless unusually often, perhaps simply because they use up too much of their resources when they drink heavily and thus lose a place to stay. Younger individuals also are more likely to be homeless; they may not know how to cope with being very poor as well as do those who are older.

But not all factors discussed in earlier chapters remain important. For example, Chapter 2 noted that military service and childhood out-of-home care were more common among those with homeless experience. Chapter 3 noted a similar relation for mental hospital experience. But looking at column 2, the role of military service and out-of-home care do not retain statistical significance. Their alleged role may only be due to demographic factors controlled for (see column 1), such as age or race. Even if one argues that the relations are close to being statistically significant in column 2, column 3 notes that when household characteristics and binge drinkers are added, all three relations are clearly lost.

How do we interpret this? The analysis reported in Chapter 2 and 3 revealed that those who have been in a mental hospital or in other institutions are more likely to live alone or with friends rather than with relatives. Thus, we suggest that such individuals are homeless more often because they do not have others to turn to in times of crisis who can help

Table 6.1

Logistic Regression: Ever Homeless
(n = 470)

	Model					
	(1)		(2)		(3)	
	Beta	(X^2)	Beta	(X^2)	Beta	(X^2)
Intercept	0.353	(0.33)	0.395	(0.35)	1.085	(2.07)
Age	-0.001	(0.05)	-0.006	(0.50)	-0.032	(9.65**)
Black	-0.620	(6.88**)	-0.521	(4.51*)	-0.492	(3.26)
Male	0.485	(5.23*)	0.370	(2.42)	0.296	(0.86)
Years of Education	0.045	(1.27)	0.025	(0.34)	-0.009	(0.04)
% of Adult Life Employed	---		0.001	(0.02)	-0.000	(0.01)
Prison Experience	---		0.169	(0.27)	0.628	(2.64)
Military Experience	---		0.541	(3.39)	0.416	(1.59)
Childhood Out-of-Home Care	---		0.572	(2.50)	0.104	(0.07)
Mental Hospital Experience	---		0.863	(7.79**)	0.329	(0.96)
Single-Headed Family	---		---		1.034	(7.91**)
Single Person Household	---		---		1.576	(25.28**)
Household Includes Other Relatives	---		---		-1.170	(12.39**)
Binge Drinker	---		---		0.918	(6.37*)
Improvement X^2	11.93*		16.21**		77.44**	

Note: Numbers and percents are rounded.

* $p < .05$
** $p < .01$

65.84 percent of the analyzed cases have been homeless and thus comprise the "ever homeless" (relatives or spouses). This is in opposition to some views, because institutional experience does not appear to lead to any other disability or sense of alienation that makes homelessness more likely, once these factors are controlled.

Thus, for example, many say that the deinstitutionalized mentally ill are not able to take care of themselves in a general way. But the results suggest that the mentally ill who have been in a mental hospital are as able as others to make use of resources that help them avoid homelessness in a general way, once they are already very poor. They have not necessarily budgeted more poorly, had arguments with landlords, and so forth. Rather, the major problem is that larger groups of such individuals simply lack a family to turn to.

Some might argue that this finding involving mental hospitalization, in particular, occurs because those who are mentally ill usually drive away their relatives. But, when we attempted to correlate symptoms of mental illness as measured by the GSI with living in a one-person household, no statistically significant relation occurs. There is no proof that, among members of this sample, the mentally ill are more likely to drive relatives away.

Earlier chapters revealed that those who were once in a mental hospital are unusually likely to live alone--even if mental illness does not relate to this. A more plausible causal chain thus might start with the premise that, for unknown reasons, some very poor individuals have mental health problems. Some of those who have such problems live with families; some do not. Those who do not live with families (who perhaps are more likely to drive relatives away, or to have fewer relatives than other individuals with mental health problems) are more likely to spend time in a mental hospital. Perhaps this happens because they have fewer individuals to turn to in times of stress. In addition, such individuals are more likely to be homeless because of the lack of ties with others who could help in times of crisis. We will later return to reasons why the family is so important.

Another key finding is that race loses statistical significance in this final equation, even though column 1 suggests that blacks are less likely to have been homeless at any time. Once again, the role of relatives stands out; fewer blacks live alone and thus many have ties that help them avoid being homeless. The relation of race to homelessness thus disappears when controlling for household characteristics.

On the other hand, the variables many expect to "cause" homelessness which we found to be unimportant earlier on (among the very poor), such as work history, do not explain homelessness in this equation, no matter what is included. In many ways the homeless look like the very poor.

Mental Health Symptoms

What about mental health? Table 6.2 reports a model that adds the GSI, the best single measure of mental health status. (This variable is reported in a separate table due to the fact its use is controversial. Symptoms may increase as a result of homelessness, not as a cause; if this is true, we should not even consider the variable. The reader thus should treat the results reported on this table with caution.) Results confirm that those who have higher scores, and thus perhaps reduced mental health, are more likely to have been homeless.

Table 6.2

Logistic Regression: Ever Homeless, Mental Health Scale Added
(n = 469)

	Beta	(X^2)
Intercept	0.658	(0.72)
Age	-0.033	(10.12**)
Black	-0.4877	(3.14)
Male	0.317	(0.98)
Years of Education	0.001	(0.00)
% of Adult Life Employed	-0.000	(0.01)
Prison Experience	0.645	(2.66)
Military Experience	0.422	(1.62)
Childhood Out-of-Home Care	-0.024	(0.00)
Mental Hospital Experience	0.074	(0.05)
Single-Headed Family	1.122	(4.05**)
Single Person Household	1.705	(27.87**)
Household Includes Other Relatives	-1.148	(11.75**)
Binge Drinker	0.647	(2.91)
GSI (Mental Health Symptom Scale)	0.212	(6.07*)
Improvement X^2	120.38**	

Note: Numbers and percents are rounded.

* $p < .05$
** $p < .01$

65.76 percent of the cases have been homeless

However, when this variable is added, the relation of binge drinking to homelessness loses statistical significance. Perhaps those who binge drink also have reduced mental health; both variables partly represent the notion of the "pathological." But as mentioned in Chapter 3, adding another variable that measures whether a high score on the GSI and never having been in a mental hospital together predicts homelessness adds nothing. We conclude that under current conditions, withholding this form of mental health treatment does not result in homelessness for those with high levels of mental illness.

Currently and Never Homeless

This role of pathologies is even less certain than it appears. There is a possibility that individuals who have been homeless in the past but are not now homeless are the most likely to have such problems as binge drinking (see Chapter 2) and symptoms of mental illness (see Chapter 3) that they contracted after becoming homeless. Perhaps the traits are only common among very poor individuals who have been homeless but now are domiciled.

Indeed, in Table 6.3, where the previously homeless are removed, the relations between homelessness and both the GSI and binge drinking disappear and do not even approach statistical significance (despite the fact that most other findings do not change).

It is thus very possible that mental illness and alcoholism do not really "cause" homelessness. At best, it might be that the face of homelessness is changing, so that the currently homeless are less likely to be "pathological" than were those who were homeless, in the past (the previously homeless).

Table 6.3

Logistic Regression: Never vs. Currently Homeless
(n = 315)

	Beta	(X^2)
Intercept	1.135	(1.35)
Age	-0.059	(17.70**)
Black	-0.880	(6.48**)
Male	-0.364	(0.83)
Years of Education	0.008	(0.02)
% of Adult Life Employed	0.002	(0.16)
Prison Experience	1.171	(3.99*)
Military Experience	0.747	(3.42)
Childhood Out-of-Home Care	0.108	(0.05)
Mental Hospital Experience	0.538	(0.02)
Single-Headed Family	1.530	(10.45**)
Single Person Household	2.183	(25.73**)
Household Includes Other Relatives	-2.489	(14.23**)
Binge Drinker	0.520	(1.16)
GSI (Mental Health Symptom Scale)	0.283	(1.09)
Improvement X^2	131.08**	

Note: Numbers and percents are rounded.

* $p < .05$
** $p < .01$

49.09 percent of the cases are currently homeless

There is a "new" relation in this equation which indicates a higher chance of homelessness for those who served time in prison. This is perhaps surprising. It might suggest that those who have been in prison are either more willing to be homeless or less able to obtain whatever services are needed to avoid homelessness. Because the relation does not occur except when the previously homeless are removed from the equation, the results might suggest that this trend may be important for the current group of homeless individuals and not for those who had been homeless in years past. Could it be that, in a tight job market, a record is a strong barrier to obtaining a job? The results from this table also suggest that blacks are less likely to be in the currently homeless group.[3]

Current Homelessness

While the above helps explain lifetime homelessness, earlier analysis suggests an important role for tangible issues over other issues in explaining current homelessness. Relations involve current work, welfare, and housing problems, with a secondary role for psychological problems. Do these continue when various factors are controlled?

Table 6.4 reports equations attempting to explain who is currently homeless and who is not (among all members of the sample). The equation includes the obvious control variables, noted in column 1, which are not discussed because they cannot easily be called "causes" of currently being

---

[3] As best as we can tell, there is no special effect of having become homeless while simultaneously losing ties with others. When the variables involving arguments with others as a distinct cause of homelessness (see Chapter 2) is added before our household measures, the relations involving institutional experience are not heavily affected. The household measures continue to be important, when added next to the equation.

Table 6.4

Logistic Regression: Currently Homeless
(n = 423)

	Model					
	(1)		(2)		(3)	
	Beta	(X^2)	Beta	(X^2)	Beta	(X^2)
Intercept	0.429	(0.31)	1.509	(3.29)	1.110	(1.70)
Age	-0.039	(14.22**)	-0.045	(16.73**)	-0.050	(20.20**)
Black	-0.752	(8.54**)	-0.263	(0.87)	-0.384	(1.76)
Male	-0.472	(2.19)	-0.857	(6.13*)	-0.873	(5.97*)
Years of Education	0.053	(1.18)	-0.066	(1.65)	-0.056	(1.14)
Single-Headed Family	1.041	(5.91*)	1.468	(9.89**)	1.360	(8.26**)
Single Person Household	1.138	(10.57**)	1.508	(14.17**)	1.686	(16.60**)
Household Includes Other Relatives	-2.496	(15.37**)	-2.694	(15.53**)	-2.470	(12.86**)
Binge Drinker	0.152	(0.26)	-0.058	(0.03)	-0.000	(0.00)
Receives Welfare	---		-1.973	(43.60**)	-2.020	(42.47**)
Shelter From Family (last 30 days)	---		-0.243	(0.49)	-0.008	(0.00)
Work Income	---		-0.002	(4.95*)	-0.003	(5.75*)
Pays or Paid Rent	---		---		0.001	(13.90**)
Improvement X^2	92.21**		52.43**		13.90**	

Note: Numbers and percents are rounded.

* $p < .05$
** $p < .01$

34.62 percent of the cases are currently homeless

homeless above and beyond their contribution to having ever been homeless. (Nevertheless, the control variables predict, to a statistically significant degree, current homelessness. The homeless are younger, less frequently black, more often the single heads of families or living in a one-person household, and less often living in a household that includes relatives.)

Most important, relations reported in column 3 (and 2) suggest that our analyses of Chapters 2, 4, and 5 are correct, and tangible issues are key. Thus, the currently homeless are less likely than the domiciled to receive welfare. They also earn fewer dollars, on average, from work (in the month of the interview). They also paid more for rent in their previous dwelling than others.

In other words, the analysis gives weight both to the importance of welfare benefits and also to the importance of other income. Naturally, receiving welfare benefits does not totally explain why someone is homeless. Some individuals receive benefits but are still homeless, perhaps because benefits are low; while others do not receive benefits and avoid homelessness, perhaps in part because they obtain income from work or live with relatives.

It should be noted that, even though the relation was large when analyzed in Chapter 5, one tangible resource no longer stands out; receiving shelter from family has no relation to homelessness in this complex equation. It appears that the relation of this variable to homelessness is completely accounted for by the variables involving living arrangements. That is, obtaining shelter apparently prevents homelessness only for those who are living with their relatives permanently, not for those who receive shelter for a few days. Apparently our sample members are in such a crisis that they are not helped very much when relatives provide temporary supports.

But the fact that the relation of rent to homelessness endures cannot be overemphasized. It remains even when household characteristics and the provision of shelter are also considered. It suggests that the expenses individuals pay for rent, and the advantages in living with others, have independent effects on the probability of being homeless (among the members of this sample). This might suggest that living with relatives or a spouse helps to do more than reduce the size of rent paid each month.

The One-Person Household

The strong role of economic factors makes one wonder if this also explains why living in a one-person household has such a strong effect on ever being homeless, in particular. The above suggests this is the case. What is puzzling, however, is that most commentators on homelessness seem to imply that those who live alone are likely to be homeless due to problems in finding a residence at a cost they can afford; yet, the logistic regressions suggest that living in a one-person household has an independent effect above that of housing costs.

One economic explanation that may solve the dilemma is that those who live in a one-person household are less likely to be able to borrow money from others when a crisis occurs. Cross-tabulations were developed to determine if this is plausible. If so, those in one-person households would have less access to a social network that might be useful in obtaining cash. (The measure of access was obtaining any cash from a given group in the last thirty days.)

Across the entire sample, this is the case. Those living in one-person households are (to a statistically significant degree) less likely to obtain cash from family members (chi-square = 39.35), from friends who have homes (chi-square = 4.04) or from homeless friends (chi-square = 4.39). The first of these relations is particularly large: 24 percent of those who live in a one-person household borrowed from family members as opposed to 52 percent of others.

Another economic reason for this high rate of homelessness might involve the lack of low cost housing options for single individuals. Even though logistic regressions revealed that living in a one-person household had an effect on homelessness that is independent from the effect of the cost paid for housing, an attempt was made to determine if there was an interaction effect. That is, we measured if living in a one-person household and having a high rent together increased the probability of being (currently) homeless. But adding such an "interaction" term to the logistic equation that models current homelessness revealed no such effect, whatsoever (chi-square = 0.30).

Another possibility might be that the relation is not economic, and those who live alone are less interested in maintaining a place to stay. Of course, our best measures of the concept of lack of interest, the measures of street culture, demonstrated no such relation. Nevertheless, an attempt was made to search for other measures.

In particular, one might argue that single individuals looked for housing less thoroughly than did others. Unfortunately, our measures of this search only allow us to compare those in a one-person household to others who have been homeless. That is, only those who have been homeless responded in sufficient numbers to questions about searching for housing. The most crucial finding is that there is no difference between those who are in single-person households and others in the number of apartments they said they found when looking, indicating no difference in search behavior.

However, it is true that slightly fewer individuals in one-person households reported that they looked at all: 65 percent as opposed to 79 percent of others. The difference is statistically significant (chi-square = 7.15). Some might argue that this demonstrates a reduced interest in finding a home among those who live alone. This might be true. However, across all our reasons of why individuals said that they did not look, responses from those who are in one-person households are no different than the others. The primary reason for not looking, as mentioned in Chapter 2, is a lack of any cash. Perhaps the major finding, here, thus is that single individuals are likely to have no cash at all. In short, the strongest evidence is that those who are in one-person households differ most in their lack of cash, particularly cash that might be borrowed from family and friends to avoid homelessness. The economic deficiency view of homelessness again prevails.

Psychological Factors

What about inabilities to make use of opportunities? These, too, may matter. Thus, Table 6.5 adds three measures (whose causal relation is less clear): our measures of self-esteem, a sense of control, and depression. Only one relation clearly exists (that is, reaches statistical significance), as the homeless indeed have higher levels of depression. Perhaps the

Table 6.5

Logistic Regression: Currently Homeless, Psychological Stress Variables Added (n = 422)

	Beta	(X^2)
Intercept	0.472	(0.24)
Age	-0.052	(20.10**)
Black	-0.178	(0.34)
Male	-1.037	(7.64**)
Years of Education	0.048	(0.78)
Single-Headed Family	1.341	(7.52**)
Single Person Household	1.700	(15.31**)
Household Includes Other Relatives	-2.265	(10.32**)
Binge Drinker	-0.060	(0.03)
Receives Welfare	-2.085	(32.30**)
Shelter From Family (last 30 days)	0.176	(0.23)
Work Income	-0.003	(5.64*)
Pays or Paid Rent	0.005	(14.24**)
Esteem	-0.239	(1.75)
Control	0.275	(2.49)
Depression	0.641	(11.66**)
Improvement X^2	177.71**	

Note: Numbers and percents are rounded.

* $p < .05$
** $p < .01$

34.71 percent of the cases are currently homeless

depressed are less likely, all other factors equal, to be able to garner their resources and thus to avoid homelessness.

Yet, even when these variables are added, economic resources remain important. Further (this is not reported in a table), the addition of an attitude toward welfare that seemed important in Chapter 4, the perception that an individual did not need welfare, did not help predict homelessness (chi-square = 0.03). We have no evidence that the homeless reject welfare to any special degree.

Current and Previously Homeless

The most strict test of traits that cause homelessness at a specific time may be needed. This compares individuals who have been homeless to those who are currently homeless. Table 6.6 compares the two groups.

As one might expect, the two groups differ in age: the currently homeless should be younger than those who have been homeless and have already escaped homelessness. There is no difference in race, although the currently homeless are more likely to be female for reasons alluded to in Chapters 1 and 2. There also is no difference in binge drinking, nor in any of the household arrangements. Perhaps if drinking and living in problematic household arrangements increase the probability of homelessness occurring at some point, they do not directly cause homelessness to occur or recede at a given point. These variables might be relatively stable traits whose importance is felt for those in the cycle of homelessness or at risk of homelessness. These findings (as was mentioned in Chapter 2) do not support those who might wish to reduce drinking behavior or change family arrange-

Table 6.6

Logistic Regression: Currently Homeless vs. Previously Homeless (n = 282)

	Beta	(X^2)
Intercept	1.879	(2.62)
Age	-0.038	(7.03**)
Black	-0.024	(0.00)
Male	-1.173	(10.37**)
Years of Education	-0.072	(1.34)
Single-Headed Family	0.508	(0.56)
Single Person Household	0.766	(2.32)
Household Includes Other Relatives	-1.535	(3.22)
Binge Drinker	-0.249	(0.39)
Receives Welfare	-2.484	(39.62**)
Shelter From Family (last 30 days)	0.150	(0.11)
Work Income	-0.003	(4.73*)
Pays or Paid Rent	0.005	(8.10**)
Esteem	-0.143	(0.47)
Control	0.216	(1.17)
Depression	0.413	(3.81)
Improvement X^2	117.59**	

Note: Numbers and percents are rounded.

* $p < .05$
** $p < .01$

51.95 percent of the cases are currently homeless

ments as a way of reversing homelessness: such actions do not appear to have an effect, at present, among our sample members.

Otherwise, the differences noted in equation 6.4 or 6.5 continue. The homeless pay more for rent, earn less from work, and receive welfare much less often. They also have higher levels of depression (although, given the reduction in cases, the relation is only at the borderline of statistical significance). In many ways, the basic relations we have uncovered may explain why someone who has been homeless is not; by work, welfare, avoiding an expensive apartment, and to a small degree due to a lower level of depression.

SEARCHING FOR HOMELESS TYPES

One may not accept this line of reasoning for all. Thus, Chapter 1 noted that homelessness is a long-time or repeated phenomenon for only some individuals. One might wonder whether "pathology," "alienation," or "identification with the street culture" are more important for this group. More experience could mean one of two things; having been homeless repeatedly, or having been homeless for a long time.

While a detailed analysis of homelessness "types" in this sense cannot be completed, Tables 6.7 and 6.8 report some simple relations between two measures of homelessness "types" and a representative cross-section of variables: whether an individual is a repeater compared to whether the individual has been homeless only once; and whether the individual has been homeless for a long or a short time. Perhaps arbitrarily, a cut-off point of two years or more is used to indicate a long-term pattern of homelessness;

Table 6.7

Selected Comparisons of Homelessness "Types": Ever Homeless
(n responding)

	One-Time Homeless	Repeater	Short-Time Homeless	Long-Time Homeless
Percent Male	64.0 (180)	83.2** (159)	67.6 (213)	87.1** (94)
Percent Black	67.3 (177)	67.3 (158)	69.1 (210)	65.6 (92)
Average Age	37.2 (134)	37.1 (159)	36.2 (220)	40.0* (92)
Years of Education	11.3 (186)	10.7* (158)	11.2 (221)	10.7 (91)
Percent Binge Drinkers	14.6 (179)	29.5** (157)	23.9 (211)	23.1 (91)
Percent in Single-Headed Family	23.6 (171)	10.5** (151)	23.4 (201)	3.0** (90)
Percent in One-Person Household	59.9 (171)	71.5* (151)	54.1 (201)	87.4** (90)
Percent Living With Relatives	6.14 (171)	9.31 (151)	9.4 (200)	6.0 (90)
Percent Currently Receives Welfare	61.5 (180)	58.0 (159)	64.8 (213)	50.3* (94)
Percent Lowest Self-Esteem (1 on a 3-point scale)	16.4 (178)	37.7** (158)	22.4 (212)	32.0 (91)
Percent Low Sense of Internal Control (1 or 2 on a 4-point scale)	19.3 (178)	28.8 (158)	20.9 (212)	30.8 (91)
Percent Highest Depression (3 on a 3-point scale)	16.1 (178)	22.0 (158)	16.2 (212)	21.3 (91)
GSI Score (Mental Illness)	0.65 (186)	0.93** (156)	0.75 (219)	0.89 (90)

(Continued on next page)

Table 6.7--Continued

	One-Time Homeless	Repeater	Short-Time Homeless	Long-Time Homeless
Percent Who Identify with Homeless	51.4 (168)	66.6^{**} (153)	58.3 (201)	62.2 (86)
Work Earnings, 30 days	$54.89 (183)	$68.38 (157)	$67.54 (221)	$56.84 (88)
Number of Homeless Friends	0.58 (184)	0.50 (154)	0.50 (212)	0.49 (87)
Percent Agreeing That:				
Street People Are Easy to Get Along With	36.5 (139)	50.8^{*} (134)	44.1 (162)	47.5 (80)
It's Easy to Get Things to Eat and Drink on the Streets	29.0 (137)	35.7 (134)	30.9 (161)	36.5 (78)
It is Dangerous to Live on the Streets	91.4 (147)	89.6 (138)	92.8 (168)	85.8 (82)
People Look at You Funny When You Don't Have a Permanent Home	84.6 (140)	87.2 (134)	86.8 (163)	81.4 (78)
It's Hard to Find a Place to Sleep on the Streets	86.0 (140)	78.9 (137)	83.3 (163)	74.9 (81)

Note: Numbers and percents are rounded.

* $p < .05$
** $p < .01$

Table 6.8

Selected Comparisons of Homelessness "Types": Currently Homeless (n responding)

	One-Time Homeless	Repeater	Short-Time Homeless	Long-Time Homeless
Percent Male	53.7 (103)	72.4** (69)	51.4 (98)	88.7** (45)
Percent Black	35.0 (101)	40.6 (68)	32.3 (95)	43.5 (46)
Average Age	35.4 (112)	35.0 (73)	33.7 (113)	38.9* (45)
Years of Education	11.6 (113)	10.4** (72)	11.4 (113)	10.6 (44)
Percent Binge Drinkers	11.8 (102)	30.0** (66)	18.0 (97)	31.7 (43)
Percent in Single-Headed Family	31.6 (97)	15.5* (67)	35.3 (94)	3.7** (43)
Percent in One-Person Household	59.3 (97)	71.3 (67)	48.7 (94)	93.7** (43)
Percent Living With Relatives	0.8 (97)	3.2 (67)	2.9 (93)	0.0 (43)
Percent Currently Receives Welfare	49.7 (103)	38.9 (68)	50.0 (98)	30.7 (45)
Percent Lowest Self Esteem (1 on a 3-point scale)	19.6 (101)	38.8** (67)	20.9 (97)	39.3 (43)
Percent Low Sense of Internal Control (1 or 2 on a 4-point scale)	22.2 (101)	27.2 (67)	19.5 (97)	33.5 (43)
Percent Highest Depression (3 on a 3-point scale)	15.4 (101)	31.3* (67)	13.5 (97)	33.3* (43)
GSI Score (Mental Illness)	0.62 (113)	0.90** (71)	0.68 (112)	0.89* (43)
Percent Who Identify With Homeless	50.9 (98)	57.2 (65)	53.0 (94)	58.2 (41)

(Continued on next page)

Table 6.8--Continued

	One-Time Homeless	Repeater	Short-Time Homeless	Long-Time Homeless
Work Earnings	\$32.17 (110)	\$59.18* (71)	\$45.29 (113)	\$58.44 (47)
Number of Homeless Friends	0.74 (73)	0.54 (70)	0.59 (105)(41)	0.66
Percent Agreeing That:				
Street People Are Easy to Get Along With	35.0 (78)	41.6 (62)	39.1 (74)	43.3 (38)
It's Easy to Get Things to Eat and Drink on the Streets	26.8 (77)	37.8 (62)	26.7 (73)	42.8 (37)
It is Dangerous to Live on the Streets	92.8 (86)	89.2 (65)	95.3 (80)	84.6* (40)
People Look at You Funny When You Don't Have a Permanent Home	86.6 (82)	85.8 (63)	88.5 (77)	78.0 (38)
It's Hard to Find a Place to Sleep on the Streets	89.9 (80)	77.7* (64)	87.6 (76)	69.6* (39)

Note: Numbers and percents are rounded.

* $p < .05$

** $p < .01$

roughly one-third of the homeless in our sample were homeless for such a long period.

The ever homeless is used as the base for both such analyses in Table 6.7. The comparisons indicate some unique traits among those who have been homeless repeatedly or for at least two years. To a statistically significant degree, repeaters are more likely to be male and to have fewer years of education. They are also more likely to be binge drinkers. They are less likely to head families with children, and are more likely to be in a single-person household. The repeaters have lower self-esteem, a higher score on the scale of symptoms of mental illness, and also more readily identify with other homeless individuals. With respect to the five measures of ease of getting along on the street, the repeaters generally find it easier to get along, but differences are rarely statistically significant.

Similar results occur when long-timers are compared to other individuals. The long-timers are more likely to be male, are less likely to head a family, and are more likely to be in a one-person household. They are a bit older. In this instance, results involving years of education are not quite statistically significant, nor are results involving binge drinking. However, the long-time homeless are less likely to be receiving welfare. While they generally have less "normal" scores on measures of esteem, depression, and so forth, differences are not statistically significant.

Turning to Table 6.8, similar but not identical differences occur when examining the currently homeless. Please note, however, that the sample is so small that statistical significance is difficult to reach.

We do not want to make too much of these results, but can comment on some of the general findings. Most important, those who have been homeless for a long-time or repeatedly are much more likely to be males who live in a one-person household. Repeaters are often binge drinkers; but these individuals do not necessarily spend more time on the streets than other homeless individuals. However, the long-time or repeat homeless individuals have other traits that might indicate a more chronic condition. They find life on the streets somewhat easier; they have less education; and they are more depressed or in some psychological crisis.

The evidence is admittedly mild, but it might suggest that the long-timers or repeaters have more problems beyond poverty. Given higher levels of binge drinking, depression, mental illness, living alone, and also their perhaps advanced ability to survive on the streets (on some comparisons), such individuals may be less willing and less able to move out of the homeless life-style. And, given the lower levels of education (for some comparisons), these individuals may have fewer resources with which to do so. They may be more "pathological," "alienated," "identified with the street culture," and also less skilled.

The evidence is bolstered to some degree by the comments of service workers. Most believe that the long-time homeless are a much more difficult population with which to deal. These homeless individuals are said to be more frustrated, have given up on themselves more often, and have given up on the social service system (fewer currently receive welfare, for example). Long-timers have fewer work skills and probably have not worked more than on a day labor basis for a long time. They can live more successfully on a day-to-day basis while homeless. This group might need particular, special, services if they are to escape.

CONCLUSION

As will be discussed more fully in the concluding chapter, the results point to a rather small set of factors that are particularly important in studying homelessness. It must be stressed that these are factors that may be associated with homelessness among the very poor; but the number of factors that cause people to be very poor must be much wider. Basically, the homeless, compared to other members in the sample, tend to be those who have fewer resources or higher costs. They pay more for rent, earn less from work, do not as often receive welfare, and live in household situations in which, apparently, financial problems more easily become crises.

The extent to which the homeless are unusually "pathological" appears to be limited. Alcoholism might cause a few individuals to become homeless above and beyond its contribution to extreme poverty, but one must remember that only about 20 percent of the homeless appear to be alcoholics. Those who have higher scores on a scale of mental health problems are also more likely to be homeless, but again, the difference appears to be modest. Both variables are important only in some equations.

However, there is perhaps mild evidence that those who have been homeless more than once, or for a long period, are more likely to have such "pathological" traits. In other words, perhaps the long-time homeless have many more problems. They may have more economic problems because of lower educational levels and also because they do not share expenses with relatives as often; they also appear to have more psychological problems. Such individuals might be particularly difficult to serve.

Chapter 7

Summary and Conclusion

Chapter 1 noted that two types of extreme views capture the range of explanations for homelessness. One stresses individual causes of homelessness, such as "alienation" and "pathology." The alienation view suggests that homelessness is bound to--and perhaps caused by--a semi-voluntary withdrawal from society. This includes a break from friends and relatives, (in some theories) an identification with the "street culture," a general preference for separation, or a refusal to use social institutions. Such traits are sometimes said to have other causes, such as alcoholism or other pathology.

A somewhat more recent claim is that mental illness or other pathologies directly result in an inability to function in society. Some authors claim that these are not completely tied to semi-voluntary alienation, but to involuntary isolation. This is the strict "pathology" view.

Individual views do not stress the role of social institutions very fully. Such views thus might at most suggest that the homeless do not wish to, or are not able to, make use of the economic system or the social service system. More recent perspectives stress that protective help from service agencies might avert homelessness for some.

The extreme polar position stresses the ties between homelessness and poverty, in general. This "environmental" view suggests that the homeless include those who are still desirous of a regular occupation and place to live but who do not have the human capital to attain this position. Although it is acknowledged that the homeless are those with the fewest job skills, a lack of resources is generally tied mostly closely to problems in the housing market, the job market, or the social service system.

Both positions imply that the long-time homeless are characterized by alienation and pathology, regardless of the cause of the original incident of homelessness. If there are any differences among researchers, it is on the extent to which homelessness is considered to be identical to long-time homelessness. To many who follow the individual pathology approach, homelessness is seen as a permanent status, something individuals fall into and from which few recover. While this varies, some authors who are identified with the environmental approach are more likely to consider homelessness as cyclic. Many of the homeless might attempt to work and might escape homelessness for various periods. But economic problems can reverse any gains.

While there is some evidence for each stance, these assertions and arguments have not been totally confirmed or denied by research. Some might argue that the earlier literature clearly demonstrated the nature of homelessness before 1980 and determined that it was bound up with alienation or pathology, but this is not completely the case; such studies are flawed or even ambiguous in their findings. For example, much of the pre-1980 research examined those who lived in housing units that are designed for single individuals. Such studies claim that the homeless are alienated because they live alone. But these individuals were not, technically, homeless. Further, individuals who live in cheap, single resident units naturally tend to be alone and not with families; they may not even represent all of the homeless. Finally, evidence on the alleged alienation of the homeless from friends or on general pathologies is not conclusive in most such work, except for evidence on a high level of alcohol consumption and possibly alcohol abuse (Sutherland and Locke, 1936; Bogue, 1963; Bahr and Caplow, 1974).

More recent studies often present limited amounts of information and assume rather than prove one or another of these models. We have already mentioned the lack of control groups, the limits of the types of questions asked, and the failure to consider survey results in light of information about social institutions.

The present study is an attempt to deal with many of the limits of other studies. It broadly surveys many issues, and it examines the homeless population in light of a comparison to other very poor individuals. It also examines social institutions and attempts to explain the results of the survey in light of this examination.

No one study can address all questions about the homeless, and the current investigation is no exception. Limits to the inquiry relate to its sample of individuals, its perspective in examining social institutions, its time frame, and so forth. Nevertheless, we are confident that the investigation helps specify, in more detail, the usefulness of the theories. It also helps to suggest policies that deal with the problems that appear to be most central to the issue. This chapter thus summarizes the findings and also presents policy implications.

HOMELESSNESS RECONSIDERED

The guiding principal of this research is that the homeless are best viewed in the context of the nature of extreme poverty. In comparing the validity of the perspectives, it is thus best to present our findings on homeless individuals in two stages, first characterizing the entire sample, and then discussing the unique characteristics of the homeless.

Characteristics of the Very Poor

Although this group differs from the Chicago population in many ways, there is a fair amount of diversity among the entire sample of the very poor. Nevertheless, the patterns are not surprising. A large part of the sample includes single men, and a smaller component represents single women. There is also a fair representation of women with children, but few intact families. Compared to the general population, single men are overrepresented; women with children are found in the group of the very poor about the same extent as would be the case in a representative sample of Chicago households. Apparently many women with children use AFDC and perhaps help from relatives to avoid the crisis of extreme poverty. The population is not particularly young, although for reasons that might have to do with social programs, very few elderly individuals are included. As one might expect in a sample of the poor in Chicago, minorities comprise most of the sample.

In terms of economic status, some perhaps unexpected patterns begin to develop. The very poor in the sample usually self-rate their family background as "average" or slightly below average, economically. As opposed to a common stereotype, most of the members of the sample at one time had what might be typical working class jobs for relatively young, minority individuals. However, many had their best job about ten years ago and have worked sporadically since that time. While about one third of the sample now works, for others, there has been a long gap since the last steady job was held. It thus appears that the sample members generally "fell" from blue collar jobs as the economy changed, and that many could not easily shift occupations due to a limited education as well as the dearth of such jobs in Chicago. In other words, there is some support for the "environmental" perspective when the entire sample is considered.

The theme of alienation must be treated with caution. If unusual childhoods that include separation might cause the trauma of alienation as an adult, some members of the group are vulnerable because they were in out-of-home care as a child. However, only a small number is involved. Similarly, the very poor do not currently seem to completely lack an interest in improving themselves nor do they withdraw from society. A good proportion of the sample is currently looking for work; a number have, or are, making use of social agencies; the vast majority have some social contacts. It is true that only one half of the sample had married and that very few are married at present. But the lack of marriage might be a result of the disorganization caused by poverty, not a result of alienation. And, about half of the sample members live with others, not alone.

Nevertheless, at least a moderate proportion of the group has few or no social contacts, and the typical member of the sample does not have a large number of them. Whether this is caused by poverty, is a reflection of living without a spouse, or is a trait that is somehow linked to a "cause" of extreme poverty, is unclear.

Insofar as individual "pathology" is concerned, there is an overrepresentation of alcoholics in the sample. There also is some overrepresentation of individuals who have been in a mental hospital. But only about ten to 20 percent of the sample may be so categorized. While some proportion had been in prison, this group represents only about one tenth of the sample.

The entire sample also demonstrates elevated scores on the measures of mental health symptoms we adopted. It is, however, unclear what exactly to make of this. It might be that mental health problems in some ways contribute to the lack of attainment of members of this group. But the difference in mental health status across social classes in numerous surveys is so great as to make many experts question whether the measures are at fault, or whether the differences are effects, rather than causes, of extreme poverty.

While these may not usually demonstrate serious pathologies, sample members are clearly under stress, because day-to-day life is difficult. Hunger occurs on occasion to many, while poor medical care, low self-esteem, and high levels of depression are common. Individuals are often dependent on welfare, yet a large proportion perceive welfare officials in a negative light, and about half of the sample has had some negative agency experience. Incomes are remarkably low, particularly when compared to rents; and with much shared living, overcrowding is probably quite common.

In sum, among the poor are a higher than average number of individuals who might be isolated and alienated, with particular alcohol or mental health problems. Most seem to be individuals with low levels of human capital in a problematic economy.

Nature of Homelessness

The economic life histories of the homeless are not all that different from those of other very poor individuals, evincing severe economic problems of those with little human capital in a difficult economic period. When comparing those with homelessness experience and those without it, for example, general patterns of work and work experience are similar. There are also similar patterns of education, marriage, and family economic history. The homeless did not experience a particular economic "slide" that other members of the sample did not experience.

There are, however, a larger than expected number of individuals with life problems or background difficulties. Mental health hospitalization and alcoholism are slightly more common among those who have been homeless; a larger proportion served in the military or were in foster care as a child. On average those with experience of homelessness have more mental health symptoms as measured by the standard indices employed.

Such individual problems are but a part of the story, however. The measure of mental illness adds only a modest amount to the explanation of who has ever been homeless; alcoholism, as best as we measure it, occurs in a minority of the sample. Moreover, although alcoholism may be independently related to homelessness, many measures of pathology and alienation are not. Indeed, some of the mental health admissions occurred to after they became homeless, and might represent in part an attempt to escape the streets temporarily. Pathology is thus only a secondary explanation.

Insofar as alienation is concerned, military service and out-of-home care might measure estrangement and are more common among the homeless. But the traits are not statistically significant in the final equations.

One key trait that helps reduce their effect involves living arrangements. Those who are homeless or who have been are more likely than others in the sample to live alone or with their children but with no other adults.

They were less likely to double-up with relatives--even before becoming homeless.

While this might seem to indicate general "alienation" from society, we do not believe that the evidence supports this view. The homeless keep about as many friends as other poor individuals when one adds homeless friends into the equation; the homeless are not alienated in this sense. And, they are not alienated in the sense of claiming not to desire to work, or in having refrained from using social agencies; they have used agencies more. Rather, such individuals only lack specific important ties. The best guess is that some used up their informal supports, and that many might have had fewer of them, to begin with.

Aid from relatives that is short of sharing living accommodations does not appear to be useful in avoiding homelessness. Indeed, some of the homeless receive help from relatives, but it simply is not enough to enable them to avoid the homeless state. We cannot directly measure whether other individuals could have lived with relatives if they were willing or if the relatives were willing. However, taking in a relative is quite a burden to assume--probably too much for many families with children, for example, when the individual to be taken in has been poor for many years and might not easily reach independence. We are thus inclined to believe that relatives are not a possible resource. In fact, while the latest spell of homelessness is in some instances caused by an argument with a relative, this is not often true; most individuals were living alone or with their own children before the latest spell of homelessness.

Resources. Otherwise, those who were homeless seemed to be victims of recent life events that result in an inability to cope with extreme poverty.

Perhaps most important, they are individuals who make less money from work at the moment, or who paid an unusually high rent in their last dwelling.

One related set of issues involves problematic interaction with other institutions--the social service and income maintenance systems. Many alcoholics have used treatment programs, but for reasons we cannot examine, are still drinking. Alcohol consumption seems to be independently related to having had one or more spells of homelessness. Services thus often were not successful for this group. Some of the mentally ill seem to have become homeless a year or more after leaving a mental hospital. Further, homeless individuals were less likely than others to have had a placement plan upon release. Since this was especially true of these individuals who had been homeless prior to hospitalization, it might be that such individuals had no one with whom to be placed and also did not really need or desire outplacement help. Most of the hospitalized group apparently became homeless due to the same type of economic problems other homeless individuals face. Nevertheless, it is likely that the mental health system is not very strong in undertaking the special material help this group requires.

Similarly, some of the homeless lost contact with outpatient care. While timing is unclear, some of these might have been able to avoid homelessness if outpatient care had been aggressive in pursuing material aid. We recognize, however, that this is not the typical function of mental health workers.

The lack of welfare benefits is a very important contributor to homelessness. A small number of individuals never applied, and for some, recent lack of experience with the welfare system might be due to a preference or desire to be independent. But the majority of those who have no very recent experience apparently would be willing to accept help.

For SSI, a lack of recent application among many who are probably disabled seems to be associated with homelessness. There also is evidence that homelessness occurs, to some degree, among individuals whose attempt to attain, or reattain other aid, had been rebuffed. For the AFDC system, certain rigid rules, needed proofs, or cumbersome mechanisms are partly at fault. For GA, a very important problem is the failure of the homeless to completely cooperate with regulations that appear to relate to the work program. This program might be unrealistic for many individuals.

Transitional shelters seem to help those with children obtain AFDC benefits. However, crisis services before the spell of homelessness might be more efficient. It takes a long time to help such families find housing once they lose it, even if they have welfare benefits. Perhaps ties to relatives have become broken, apartments are hard to find at the price, and many shelters do not have particular resources to help. But for those in overnight shelters or whose main contact is a meal program, the level of advocacy is quite low. This might in part account for a failure of individuals to obtain benefits. In sum, there is some evidence for an environmental perspective.

Homeless History

Much of this review talks of the "homeless" as one group, but one other finding of this study is the existence of a large group of individuals who, while not now homeless, have been homeless in the past. This contrasts with recent studies of single resident occupancy hotels or of GA recipients, in which few such individuals were located. About half of those who were not currently homeless had been without a home, and many such individuals had long histories of sporadic homelessness (one must conclude that many who escape homelessness remain very poor). Homelessness has affected many individuals who are still vulnerable.

Homelessness careers also vary. About half of the sample had been homeless only once; many such individuals had spent a relatively short period of time in this state. Although nearly any period of a few months might be personally devastating, the existence of so many short-termers has not been adequately addressed by most researchers.

The other half of the sample had been homeless for longer periods. However, in contrast to the common claim that homelessness is permanent, a pattern of multiple spells, interrupted by periods of being domiciled, seems to be common. As some of those espousing the environmental view might claim, homelessness indeed is a repeated, periodic event for many. It is only a small group that appears to represent the long-time, chronic, continually homeless population.

The theories that stress pathologies or alienation seem to be a bit more apt when discussing those who have been homeless more than once, or for a longer part of their lives. This group is more likely to include the binge drinkers and those who live in a one-person household. Such individuals generally have even higher levels of depression, poor mental health, and less of a sense of control.

However, this group does not differ dramatically in access to, or identification with, the street culture. Further, because there appears to be some relation between education and extent of homelessness, there is some evidence that the differences may in part be an effect of the lack of "human capital." One would nevertheless guess that, no matter what the original cause, the long-time and repeater groups experience more pathologies.

Social Institutions

While it is in its very nature less exact, data on social institutions also reveal problems that might have some effect upon homelessness. We have confirmed the often noted trends of reduced availability of housing for certain individuals, accompanied by disproportionately growing rents for the very poor. At the same time, blue collar jobs appear to be disappearing in Chicago. The welfare system also appears to be deteriorating in many ways, including the ease of access and the level of benefits. Work requirements are becoming quite strict and might indeed be administered in ways that result in instances in which individuals are incorrectly suspended from welfare rolls. There also are some gaps in mental health services, although the trends do not appear to be so unfavorable in that services are now modestly redirected toward the chronically mentally ill. Behind all of this is a demography which is more and more biased toward vulnerable populations.

It is distressing that variables that are linked to homelessness at an individual level to some extent relate to deteriorating aspects of the environment. The homeless often lost blue collar jobs some time ago; they pay higher rents than other very poor individuals; they have had problems with welfare; they use social services; and they often are members of growing demographic groups, particularly single individuals.

Certainly, the one point in time survey data cannot be used to fully explore the link between a changing environment and the fall into, or continuation of, homelessness. However, the possibility of such a link is clearly strong in these results. That is, because the homeless are characterized by resource deficiencies that have increased in extent in recent years, or troubles with services that have experienced cut-backs, the environmental changes may be tied to the rate of homelessness. Institutional forces thus are likely to be heavily implicated in this social problem.

The Theories Reconsidered

In sum, if one were forced to simply choose between the two theories, the environmental approach appears to be more accurate. The homeless seem to be similar to those in extreme poverty when one looks at economic background and general life conditions. Further, many of their special traits involve immediate problems with the welfare system or with work, or higher rents and a reduced ability to share the burden of expenses. These are largely economic problems. Some problems may be caused by social change in the sense that the problems are in areas in which social resources are clearly decreasing--employment, housing, and welfare.

Nevertheless, one would hesitate to completely accept this view. The homeless differ in certain key ways; for example, they are more likely to live in a one-person household. And different backgrounds, in certain ways, contribute to this difference in a way that implies some particular disability or problem. On occasion, for example, we have linked the failure of some of the homeless to make use of social institutions to alcoholism.

We thus suggest a causal chain that adopts aspects of both the pathology and environment views. In a general way, the homeless are comprised of individuals who lack human capital, due in part to a limited education that is common among minority groups and many others in Chicago, and perhaps due to individual pathologies. These individuals seemed to manage well enough in their early 20s. However, an economic shock--probably the general decline of the economy, or perhaps a personal shock--made extreme poverty more likely. Homelessness occurs to many individuals in such poverty.

Homelessness is particularly likely to occur when individuals either do not have, or exhaust ties with relatives on which to rely, pay a high rent, are in the lowest part of their cycle of earnings, or run into trouble with the welfare system. Given the nature of living arrangements of the ex-homeless, we suspect that some potential for trouble remains even after the first spell of homelessness for many; future homelessness becomes difficult for some to avoid because many are susceptible to another crisis due to the lack of many types of resources.

These problems, in turn, may not be equally distributed. Our research suggests that the problem of living alone, that is, the lack of ties to others, is more common for individuals who have been in foster care as a child or have been in a mental hospital and thus may have fewer known relatives or may have alienated them. Alcoholism and mental health problems also appear to relate to negative experiences with other social institutions. But, to some degree, these problems also might simply be due to chance; only a minority demonstrate many such deficiencies.

With respect to service agencies, those who become homeless tend to have uncommon traits, and most service systems or social institutions are not established to meet them. Accordingly, this group is least likely to be served well. For example, those who do not have relatives to rely on are more difficult for the mental health system to place, and those who are alcoholics might have the most difficulty in meeting work requirements in welfare.

The institutional focus is also important because such individuals are particularly likely to be underserved when the service network is under financial pressure. Those who become homeless tend to have marginal, not central, characteristics from the point of view of the service system; they might be those who are mentally ill but have more severe material needs and less stable family networks, for example. They also have limited educations and cannot compete well in a declining economy. Accordingly, it is no surprise that rates of homelessness increase when the job market, welfare system, housing market, and social service systems are contracting.

In general, then, we stress the tangible, economic, events more than those involving alienation. We also stress the interaction of such events with problems with social institutions, from the family to the welfare system. But we are aware of the way in which individual problems increase the chances of extreme poverty and of extreme poverty becoming homelessness; these problems apparently increase the probability of finding oneself without welfare, without family, and without a job. And, the long-time homeless have more difficulties, which in part might suggest that homelessness increases problems, or even that the most alienated or pathological are helped the least by social agencies.

One way of summarizing this is that we suggest an "interactional" view of homelessness. This phenomenon seems to occur as a result of interaction of the general problems of the poor with a number of environmental and personal stresses. Environmental stresses involve the job market, and various social welfare institutions, and problems with families; personal stresses involve individual problems that also make it more difficult to relate to social welfare institutions and the family. Homelessness occurs when a combination of difficulties arise. The difficulties generally are economic in their direct relation to homelessness, with indirect stresses giving rise to the particular economic problems for a minority of the sample.

To put this in other terms, the "rate" of homelessness might increase when either individual or social problems increase. More individuals are certainly pushed "over the edge" when the economy becomes more difficult, welfare becomes less accessible and less generous, income from work and welfare are limited or social services are inadequate. Those who are most affected are susceptible to income or service losses and also cannot adjust to such losses. An increase in the number of such individuals contributes to the rate of homelessness.

IMPLICATIONS FOR POLICY

These notions about homelessness have policy implications. They suggest that, to some degree, the problem of homelessness is bound up with the problem of extreme poverty. At the same time, the homeless are so unique in some ways that one can help them avoid homelessness even without focusing on extreme poverty. The decision concerning which problem should be addressed is a public policy choice.

This insight, along with the remaining results, suggest policy implications ranging from prevention to reversal of homelessness, from focussing on special groups to considering the general nature of extreme poverty. In all cases, we focus only on Chicago; many of the suggestions may be useful in other locations, but not in all locations because the social institutions might differ.

Prevention

It is no new insight that an improved economy, particularly one in which opportunities for those with limited education increased, would be likely to reduce the flow into homelessness and perhaps keep some who have been homeless once from falling into that state, again. But this view still needs to be stressed. If there were more jobs in Chicago, particularly for those with limited education, clearly there would be decreased levels of extreme poverty and thus homelessness. That is, large proportions of the very poor can work, are willing to work, and have worked. While the group obviously includes those with the most limited work skills and possibly a large number of problems in work habits, the apparent correlation of the increase in homelessness with changes in long-term unemployment rates and the results of the survey suggest that economic changes are vital.

To be sure, no one could suggest massive changes in economic policy on the basis of a survey of a small group of individuals. And, this study cannot suggest specific policies of economic development because it did not attempt to examine the broader social forces leading to economic change. Our major point is that fighting homelessness is an uphill battle in a flat urban economy, one that must tap special resources if the economy itself will not alter. Unless an unanticipated economic upturn occurs, we must expect to need a relatively large number of special programs to deal with extreme poverty and homelessness in a piecemeal fashion for years to come.

Nevertheless, prevention may be possible. To be sure, one special problem in dealing with homelessness is that, at any one time, it only affects a minority of those in need. These are very poor who have particular traits and are affected by a lack of supportive services or institutions in particular ways. Prevention often involves spending considerable sums for a larger group. Another document would be needed to address the cost-benefit issue and the more general issue of piece-meal reform in a time of many service shortages. Nevertheless, some efforts may help provide the tangible resources that may prevent homelessness.

Work Programs. In light of the lack of jobs for the unskilled, some type of work programs might best prevent homelessness by turning the very poor into the employed. We are not referring simply to work training or working for welfare benefits. Some type of integrated program, in which individuals are offered some sort of job, itself, is needed. Jobs are preferable to welfare or other types of income maintenance; if the job market is so tight, the small number of individuals who have not found jobs for so long that they are in extreme poverty or threatened with homelessness needs to be provided work.

We propose a special program targeted to this group, because it is unrealistic to expect members of this sample to do well in traditional work programs. First of all, most such programs focus on individuals with more skills and probably with higher levels of self-esteem. The very poor, and particularly the homeless, would be the most difficult to train and the least likely to be accepted in such programs, let alone to succeed in them. Second, a more regular existence, including a place to stay and sufficient nutrition, are needed before any job program might succeed. Third, given their negative experiences with some agencies and lack of expectations about programs, one would imagine that something as tangible as work for pay would be needed to attract the very poor.

Accordingly, such a program might need to involve sufficient financial security for individuals to obtain a regular place to stay. It would also require services to help individuals secure housing and manage other day-to-day matters. The work program, itself, would need to be designed particularly for this group. We might suggest a focus on first providing a job. This is in keeping with the notably tangible mind set of the homeless, in particular. Later, more training might be useful.

We do not claim that such a program would be cost-effective from the narrow view of governmental expenditures. Indeed, because many of the homeless do not obtain welfare at present, it would cost more to implement such a program than to avoid dealing with the homeless. At the same time, training in general does not always have positive cost-benefit statistics and might not for this group.

Rather, such a program would need to be more concerned with improving the status and lifestyle of the very poor than with success in a cost-benefit sense. Work is superior to dependency and homelessness, even if work must be supported. The benefits, in other words, might accrue to the needy or might be a sense of helping unfortunate individuals.

To be sure, there are job or work programs available right now. However, some, like Project Chance, are very short-term and have trouble dealing with those who are discouraged by years of unemployment. This program also is nonvoluntary and dispenses few resources. Perhaps due to the rigidies in sanctioning rules that occur when dealing with so many people, the program often seems to lead to welfare cut-offs among those with limited resources and long histories of unemployment. Other services that deal with recently displaced workers overlook the vast majority of the homeless and very poor.

Such a work program might best be undertaken as a small effort. It may be an alternative to Project Chance, perhaps even supported with foundation grants as well as with public funds. Agencies that specifically deal with the homeless or who otherwise are committed to the very poor are the likely candidates for administering such a program. It is recommended that small, demonstration projects occur first, so that the technology of helping this group work, which is as of now undeveloped, has a chance to become more explicit.

Work programs are placed under "prevention" because they could easily be focused on all of the very poor, long-term unemployed. It is also possible to focus work programs on the long-time homeless, alone. This would rely on the same general concept, but would focus more on reversing homelessness than preventing it.

The utilization of work programs for the long-time homeless, alone, would even be a welcome development. In the short-run, this might need to be a special, state-sponsored or locally sponsored program. In the long-run, however, federal support might be worth pursuing. In particular, the Department of Vocational Rehabilitation could easily respond if federal mandates would allow homelessness as a category for obtaining rehabilitative services. This might be most important for those who have been homeless for long periods, who apparently differ from other individuals in important ways.

Welfare. Obvious short-term financial problems also relate to homelessness. Rents are very high and incomes are very low. There is some amount of hunger among the entire sample.

Some experts favor housing subsidy or building programs, claiming that this is the best way to deal with housing costs that consume much income of many individuals. Others talk of improved health care services, nutrition programs, and so on. However, the list of unmet needs of the poor is so great that at least some attention would ideally be placed on the overall level of material assistance. That is, the survey documents a large number of unmet needs that are the natural result of a lack of income and that can lead to eviction and then homelessness.

Ideally, then, a rather substantial increase in the size of the welfare grant is needed to prevent homelessness. The grants are so low compared to the poverty level or even the cost of housing that some level of homelessness is to be expected. Given that we do not have evidence about the nature of homelessness in states with higher levels, just what higher grants can exactly accomplish is unknown. However, the fact that few individuals who receive SSI benefits are homeless suggests that this SSI level of income would be an important standard. Note that the non-homeless in the sample have a total income that averages somewhere around $300 a month, which might be sufficient for one person to avoid homelessness--although not to avoid all of the stresses of poverty.

We understand that this increase is unlikely to occur quickly. But we wish to caution about expecting homelessness to generally be eliminated if higher standards are not adopted. Any piecemeal program, just like any program that does not have an eye to the basic economy, must work around the basic parameters of the income maintenance system.

However, welfare rules seem to create problems that are even more important contributors to homelessness than problems of the grant level, alone. Changes may help prevent homelessness from occurring. While we did not investigate the welfare system with sufficient depth to describe all of the reasons for problems, it is clear that administrative and supervisory changes seem needed, particularly because some of the denied became homeless. The level of demanded proof is occasionally too high; certain individuals apparently need more help to obtain birth certificates and other documentations.

Apparently rules in the GA program are particularly onerous and may result in sanctions that precede the loss of benefits and thus homelessness. Many of the poor cannot, or will not, cooperate with the work program. So many committed workers have complained to us about insensitive administration that we believe that this is an important part of the problem. If funds cannot be increased, the program should simply take on fewer individuals and deal with each individual with greater understanding.

Another possibility is for GA to excuse some individuals from participating in Project Chance. To be sure, some might claim that, if so many people cannot meet the rules, then there are many individuals who do not demonstrate the willingness to accept reasonable conditions for obtaining welfare benefits. But note that rules vary, and AFDC programs, with a somewhat more lenient work program, does not have the same problem. Nor do more carefully designed experimental work programs in other locations. It may be the programs, not the individuals. Further, we are concerned that the rules are such that those with the greatest need are the least likely to receive benefits. The borderline individuals who cannot meet the rather difficult criteria for continuing to receive GA and thus lose benefits are those who are least likely to be able to fend for themselves.

While the current trend is to excuse fewer and fewer individuals from the work program, this thus seems to be a significant problem. It might be possible to limit the fall into homelessness by resolving it and reducing the use of sanctions. It is true that the vast majority of our sample probably can work. But the alcoholics, some of the mentally ill, and perhaps others cannot; some such individuals need to be excused, and apparently are not under the current interpretation of work program rules. Perhaps those with a five year or more period of unemployment should be excused. Such individuals are so unlikely to be able to find jobs or to be able to follow strict rules that there is no reason to include them.

Emergency Support in Welfare Programs. Baring a large increase in support, there may be more modest ways of preventing homelessness through an income maintenance emergency program that deals with crises. We admit that this might merely turn the homeless into the domiciled, very poor. It is not a solution to a general life crisis. Nevertheless, life on the streets is so dangerous, and the homeless have such obvious problems in existing day-to-day that avoiding homelessness is quite important.

We assume that, for the vast majority of the homeless, prevention demands tangible aid. While many such individuals have high levels of depression and some have alcohol or mental health problems that might interfere with day-to-day life, the lack of ability to share expenses or factors such as a lack of welfare benefits best distinguish the homeless from the rest of the very poor. In addition, we have noted that homelessness spells occur repeatedly to some. The focus should be on avoiding spells by providing resources.

For women with children, problems with finding cash for security deposits may result in homelessness; reversing such difficulties may ease the problem. Others--singles and family members--are evicted and might not become homeless if there were some type of special safety net. Others break ties with relatives and thus face severe economic crises.

We do not believe that emergency aid can solve all such problems because some crises are caused by the general low level of economic support. But a modest increase in Emergency Assistance (EA) and an extension of the program beyond AFDC recipients might be helpful. Such programs might, at the point of a crisis, subsidize individuals for a rent deposit or whatever else it might take to avoid homelessness.

For some individuals, the provision of help might be viewed as suspect--encouraging individuals to face eviction so they can receive aid, for example. Certainly, some form of rationing needs to be designed for this. But right now, the emergency programs are so small compared to other programs that over-use is not a major issue. On the basis of the experience of other states, we believe that EA should be about one percent of the grant costs, which is at least three times the current budgetary level for AFDC-EA in Illinois. It also would be helpful to extend this type of program to GA recipients at a similar level.

Who might dispense this aid? Clearly, public welfare departments can become more active. Funds can be more readily available; central approval can be reduced or eliminated; the program can be more widely publicized;

rules can broaden eligibility; workers can even be allowed to specialize in crisis aid. But for those poor individuals without welfare experience, alternate sites might be used. Many of the homeless use meal programs, for example, and a few others make use of private agencies or mental health clinics. Such agencies could, in theory, have programs that are subsidized by government, or might at least be active in referring individuals to government.

Advocacy in Welfare. Assuming no change in welfare rules, support for increased advocacy is in some sense in many people's interests--particularly given the cost to the society of homelessness (e.g., the cost of welfare benefits plus the small cost of shelter, which is paid in part by public funds). Advocacy can help individuals obtain benefits that prevent homelessness. But, advocacy, in contrast, seems to be on the decline. In SSI, the claim that financial incentives to attorneys are sufficient to help individuals apply is not true. The Illinois Department of Public Aid might become more active, and might do so in a manner that does not create a disincentive to workers and clients through the cumbersome process of applying for P3. As has been proposed by some, P3 instead should be available at the regular offices and should be equal in size to GA grants.

Perhaps a more positive step would be to fund advocates to search for eligible individuals and help them apply. For example, some other jurisdictions fund private agencies solely to provide advocates who attempt to turn state supported welfare clients into federally supported clients. If such individuals are receiving GA in some cases, this might be cost effective for the state; at the very least, it clearly might help some individuals to avoid homelessness. We suspect that, because about 10 percent of the poor, non-homeless individuals receive SSI, and because a larger proportion of the homeless have been in a mental hospital, that the current 3 percent SSI participation rate of the homeless could be brought up to perhaps 10 to 15 percent--and few such individuals would remain homeless.

There are many individuals who do not have negative attitudes toward receiving welfare but who have not recently applied for welfare benefits. Aggressive outreach is thus needed. Legal aid offices are now useful, but individuals must come in to be helped; many of the homeless apparently need help in even making the decision to come and apply. At the same time, some sort of quick action for those who have been cut-off or who cannot obtain benefits due to procedural rules would help avoid homelessness for a few individuals. Once again, a solution might be for advocates to be stationed in areas in which the homeless congregate.

There are some workers who try to help the very poor right now, but the network is not sufficient. We are particularly skeptical about the ability of workers in mental hospitals to help individuals apply for SSI. Most individuals are not in the hospitals long enough to complete the process; those without an address may never receive certain of the forms. The long SSI process encourages workers to help individuals apply for GA, not SSI, and GA is not as great a barrier to becoming homeless. Even recent changes in procedures allow workers to help individuals apply for GA instead of SSI.

One possible solution is for specialized experts to undertake this advocacy role in the mental hospitals. We are not only including the role of liaison with welfare, which now is being created, but also the role of helping individuals apply. Overworked release workers may never be able to carry out all the needed activities. Another possibility is to create a separate budget item for workers in community mental health centers, creating specialists outside of the hospital whose specific job is to help individuals apply.

Ameliorating the Effects of Homelessness

Insofar as services to homeless individuals are concerned, the evidence in this document is consistent with that of other studies, community efforts, and comments by advocates. For example, that because a typical member of our sample who is homeless reports being unable, at times, to find shelter, the claim that there are not enough shelters is confirmed.

It seems that the housing and shelter problem is most critical for single individuals because these individuals are more likely to fail to find a place to sleep at night. Even when housed, those who make use of overnight shelters seldom achieve access to welfare benefits and perhaps to other services. Expanding services in overnight shelters is one answer; more to the point, single individuals appear to require a larger array of transitional shelters.

Hunger also appears to be a significant problem for many members of our sample, whether they are homeless or not. It would be helpful to take steps to increase the distribution of food. Food pantries and soup kitchens have indeed expanded over the 1980s; but so has the need. This is only slightly more of a problem for the homeless than the non-homeless, although the lack of food is most critical for the homeless who cannot make use of transitional shelters. Even though most of the homeless are congregated around the areas in which there are shelters, as are food programs, perhaps there is need for some expansion in programs in these geographic areas.

Reversing Homelessness

It is probably much more cost effective to prevent homelessness than to reverse it; once homelessness occurs, there is a cost of shelter and of rehabilitation as well as a need for basic supports. This is why prevention has been emphasized.

Once individuals are homeless, our evidence suggests, most do temporarily escape. For most, the issue is in ensuring that escapes are more swift, and also more lasting.

The general focus for most must also be on tangible aid, in this case--aid that is not unlike what is needed for the prevention of homelessness. We have already mentioned the possible role of work programs. Obviously, welfare benefits, advocacy, acceptable welfare rules, and aggressive outreach are needed. If anything, those threatened with homelessness will need even more emergency financial aid to provide for security deposits, to help with debts, and so on. Given the apparent lack of low cost housing, at the very least help with housing searches is needed.

Drop-in Centers and Meal Programs. Some issues involve the question of where to house such service programs. One possibility is the use of drop-in centers. These indeed have expanded over the last few years to attempt to provide such services, and might continue to be useful.

While it would take a good deal of effort to carry out, it is possible to use the food programs as an additional vehicle to dispense services. Many of the homeless make use of meal programs and are at the programs locations for a reasonable length of time during the evening; a large share return most of the time. Perhaps the programs are one location in which welfare access and housing services might be placed.

The advantages of meal programs are many. Adding services would not be as costly as resorting to new institutions. And some individuals may be more comfortable working with agencies in which they had obtained meals. Further, the meal programs can serve a greater purpose than reversing homelessness. The programs can at the very same time use services to prevent crises; negotiate with landlords, counsel individuals not to vacate apartments before they receive an eviction notice, work with programs involving the welfare system, and so on. The lack of ties between many meal programs and the bulk of the social service system, at present, is indeed surprising and limiting.

Shelters and Outreach Workers. There is a special problem in overnight shelters, in which individuals stay for such a short period each day as to virtually preclude outreach. At present, service provision is not even always sufficient in transitional shelters. Indeed, it is quite difficult to provide such services in these locations, particularly when the stay is short. Funds often are not sufficient; some shelter operators do not see service provision as their function; other shelters rely on volunteers who might not be able to contribute very much more. Budgets are generally limited.

An alternate plan would be to use teams of service workers whose home base is elsewhere to provide certain services within shelters. These workers could be experts and would offer a more realistic use of resources (given the small size of some shelters). They might even be less threatening to the homeless, who might fear those who serve them but also can limit access to a shelter.

One possibility would be to use city or state service workers for the task. But right now, city staffs are not even sufficient to fully find shelters for individuals, and the central unit can only intervene in some crises. It thus would be ideal for some level of government to establish separate programs for the homeless. As we argued in the case of work programs, homeless individuals generally may not do very well in general service programs. Perhaps chronic homelessness--such as having spent two years on the street--can be made an eligibility criteria for special programs. Or perhaps detached workers at some level can be appointed to deal with homelessness issues from shelters, drop in centers, and food programs.

We realize that particularly with continuing federal cuts in services, it is rather difficult to establish separate programs. We do not at all claim that the state or city is not interested in the problem, just that it is difficult raise the funds for services. Perhaps small, demonstration projects could be established through the private sector if other funds are not available.

Special Populations

There are also special populations that have not been served very well at any stage--prevention, amelioration, or reversal. These individuals could use more services, particularly within the agencies with which they already interact. The services follow the general stress on the tangible, argued for above, but in slightly different and specialized contexts.

Alcoholics. There are a number of alcoholics among the homeless and also among the other members of the very poor. Some do not have access to any welfare benefits; they are in fact underserved to a statistically significant degree. Many have at one time gone to treatment services; few go, at present. And, this group clearly has unusual material needs, even compared to other homeless individuals.

Alcohol services, while needed for only perhaps 20 percent of the homeless, are thus a high priority. We are not sure precisely what services are needed. Perhaps existing programs need to accept, or search for, the homeless; perhaps the homeless require special programs. In any case, in our experience, most alcohol programs deal with drinking and psychological problems. Material needs should be dealt with more fully--particularly the issue of welfare access.

It is even possible that, for some of the homeless, a ready cure to alcoholism is not available, for a good share have gone to programs but continue to drink heavily. Because some such individuals may be able to work, perhaps the types of work programs referred to above are indicated. But some special "care-taking" services might be necessary for some of these individuals. For example, perhaps the service model described for the Bridge in the mental health chapter can be in some way adapted for alcoholics. Such a program can help with the tangibles, such as the lack of access to welfare, which is a particular problem for this group.

The lack of SSI benefits for this group is striking. One problem is that many alcoholics are not directly eligible for such benefits. This is a national, not a state issue; however, it clearly demands some attention, particularly for the group who have also been homeless. It is unlikely that many such individuals will easily find work.

Mentally Ill. Insofar as the mentally ill are concerned, most do not seem to be so disturbed that they cannot maintain a place of their own, although they often cannot live with others very easily. Most seem to be homeless due to the same lack of tangible resources as other homeless individuals. For example, few are homeless when receiving SSI. Most probably can avoid this state when they garner resources.

There is little evidence that those mentally ill individuals who become homeless are unusually likely to be ignored by the mental health system; those who are homeless and have been in a mental hospital were treated only slightly differently than others. It is true that a large number of individuals with high scores on the index of symptomatologies have not received treatment, but the difference is basically in line with the elevated levels of problems of all of the homeless compared to the very poor in the sample.

However, those with homeless experience have the characteristics that are most difficult to address. For example, perhaps because of a previous lack of a firm home or even because they lack the willingness to be helped, fewer obtain an out-placement, and many give up on community treatment about the time they become homeless. Thus, if the mentally ill are to be kept from homelessness, special care, not average care, seems to be needed. This might include a more aggressive search for those who lose contact with the community mental health centers. It also is likely to involve a capacity to deal with material needs of this population, perhaps including more active attempts to intervene with landlords in crises, and more active advocacy with public welfare agencies. As has been mentioned elsewhere, exempting this group from work programs in GA if they are not SSI eligible is one issue; obtaining SSI or perhaps Veteran's Benefits is another.

It is possible that a few are so disabled that they cannot use housing opportunities. For these, a small number of additional beds in community facilities may be needed. Given recent changes in funding and regulations for intermediate care facilities, this is indeed a growing issue.

The lack of intensive out-patient service programs is the more general issue, however. Some very good programs exist, but they are rare. In addition, their criteria may exclude many of the homeless or those who are potentially homeless. The vast majority of the homeless who have been in a mental hospital have less than five hospitalizations; but five is a common breaking point for many intensive service programs. Again, perhaps a special categorical eligibility for those with a long history of homelessness is needed.

There is also some evidence that those who are homeless have become detached from community mental health centers. The survey data give us only slight clues about this, but the case study material provides a bit more detail. It appears that agencies vary greatly in their ability to extend outreach or to deal with those who drift away. Those with material problems also apparently place mental health needs as a somewhat lower priority.

The nature of "tangible" services that might help those who can be reached should be evident from other aspects of this discussion. For example, because housing and welfare problems are so important in homelessness, providing such services to the mentally ill might be important. Some community mental health centers already provide such services. The fact that some individuals cease using services might even be a very minor "cause" of homelessness in this rather indirect sense.

It might appear that there is some discrepancy between the claim that the mentally ill who are homeless often look much like the other homeless, and the call for intensive mental health services. Indeed, some mental health officials may deny that the special services are in their province at all, because so many needed services are tangible, not psychological. We recommend that such services be delivered by mental health agencies for the simple reason of access. Many of those with mental health facility experience continue contact with agencies; many have tangible problems; therefore, mental health agencies can help with these tangible problems.

We also recognize that there are some mentally ill individuals who need services but will not accept them or who have avoided contact with the mental health system. We have no unusual contribution to make to suggestions about how to deal with this group. But since many mentally ill individuals become homeless for the same reasons that other very poor people do, perhaps this group would benefit from the general services we have mentioned.

The Role of Relatives

Those mentally ill individuals who become homeless apparently do not live with relatives. What to make of this is unclear. Some evidence from the late 1960s and early 1970s suggests that some of the mentally ill are more likely to have another crisis if they live with their family. But some experts now claim that, with special supports, families might be able to deal with this group more fully. In light of controversies over this issue, the only sensible solution is to fund experiments for some type of subsidized living program--for example, with respite care, support from social workers, and so on. The experiments may help indicate the possibilities of relative support for avoiding homelessness for this specific group.

The role of relatives is also a more general issue. Because many of those who avoid homelessness, even those without history of mental hospitalization, also reside with relatives. There are some who claim that one way of reducing homelessness is to encourage claims on relatives.

While this might at times help reverse homelessness for a given individual, we are not certain that it is usually realistic. Many of the homeless have not recently stayed with relatives; few of the previously homeless move to relatives. There thus may not be all that many individuals whose families can take them in. Further, in some instances, a lack of relatives is tied to childhood out-of-home placements or pathologies in ways that suggest that relatives' support is not realistic.

However, for those adults with children, the potential success seems greater because ties with relatives often existed before homelessness began and also broke when homelessness occurred. It is possible that, for this group, some sort of counseling or treatment intervention could help to restore ties.

The general demise of social services might be implicated in homelessness to a very small degree if it resulted in a reduction of such intervention in the prevention stage. After the fact intervention at shelters might not be as successful, but it might be worth a try. Perhaps transitional shelters should focus on this to a greater extent. But perhaps city workers should focus on this issue less in looking for options for single individuals.

Reversing Long-Term Homelessness

It is clear that most homeless individuals are not long-timers, and could benefit from at least relatively straight-forward service programs that have already been mentioned. But there are some long-time homeless individuals who would be even more difficult to help. The long-time homeless seem to have different attitudes, fewer talents and skills, and may have a more negative attitude toward programs.

No obvious solutions abound for this group, at present. Perhaps we have nothing in particular to add to traditional calls for services--except to point out that our assumption is that the long-timers are a small fraction of the homeless, not the majority, and that some may respond to the suggestions we already listed. For those who cannot benefit, the call for a range of shelters and extended living programs seems to offer the most hope of care, if not of cure.

Housing

This chapter has not focused on housing to any great degree. This lack of attention is not a result of a lack of awareness. Chapter 2 noted that housing costs are quite high and that at the low income side, housing is not readily available.

Our difficulty is that the choice of how to focus on housing is a much broader issue of public policy. Certainly, one can subsidize construction of low cost housing, prevent its demise, or directly subsidize rents. But it is also possible to focus on incomes, perhaps allowing the market to respond with new housing.

There is not enough information, at present, for us to propose one solution over another. Simply put, the dynamics of the housing market at the economic "bottom" are not well-known. We do not even know exactly why there is a crisis let alone how best to solve it. All we can say is that the subject is worthy of continual attention.

We can address a number of more specific issues involving housing, however. For example, many of the homeless are evicted without a court order and thus do not make use of existing eviction programs; we believe that the tendency of landlords to ask individuals to leave without giving options should be investigated. Perhaps those on the verge of eviction should be given help in relocating and in not leaving before the court order is served. Some of the homeless have such large debts, particularly rent, that they may have difficulty finding a place to stay where they are free from bills; perhaps bankruptcy or some other means of dealing with bills should be considered.

Similarly, a very large 17 percent of the homeless sample lost a dwelling that was closed down and became homeless because of this. This percentage is very high, in part indicating that there is much troubling gentrification in Chicago. But also troubling is the apparent lack of services to place individuals elsewhere. Perhaps landlords manage to entice individuals to leave before services are offered, and many simply go; perhaps other individuals leave immediately upon hearing that a building will be torn down. There is a need for services at some earlier point in the process, as well as for attention to this problem from those who deal with the very poor and can let them know about the options they may have for relocation.

CONCLUSION

The interest in homelessness has increased as the size of the population began to increase about a decade ago. It is rather difficult to attribute the increase to one phenomenon, but the current research suggests at least partial causes for the increase. If one can assume that studies of the 1960s and 1970s actually characterized the homeless, we can look at the differences between those studies and ours to examine these causes.

It is clear that those who have a history of mental institutionalization are more likely to be homeless now than in the former studies. But this group is still small. We conclude that deinstitutionalization contributes to the increase in homelessness in a minor way. It is clear that there are many alcoholics among our sample, but fewer in percentage than indicated in earlier studies (although the measures are not identical). In Chicago, the increase in homelessness of this group, or an increase in alcohol consumption, did not cause the general rise in the rate of homelessness. But there are more homeless women with children now, and more members of minorities, many of whom do not have obvious pathologies. While studies of the earlier period did find many poor individuals who were homeless simply due to poverty, our sense is that this group has grown particularly fast. The homeless also have grown younger, with fewer poor retirees compared to poor young people in the sample. We suspect that the combination of a lack of jobs for the unskilled and reduced housing opportunities are the major concerns. Also contributing are the various problems in welfare we have mentioned, from low benefits compared to the cost of housing to problems in eligibility regulations and work programs.

This guess is not meant to imply that the "pathological" homeless are unimportant--just that such individuals indeed are now joined by those whose problem, simply put, is poverty, perhaps exacerbated by the lack of family or service supports. While it is beyond the scope of this report to examine the macro-level trends, nothing in this report should be taken as evidence that the larger problems can be overlooked.

Whatever the causes, there is clearly no simple, single solution to homelessness. Individuals fall into this state in many ways. They have many differing traits. Some belong to families, some are single; some are long-term homeless some are short-term; some will escape by themselves, and some will not.

For this reason, we have suggested a large array of policies. Each is designed to speak to a different component of the problem of homelessness in particular, or the more general problem of extreme poverty. We recognize that the proposals are complicated. But homelessness is a complicated problem. And, by offering a list, we make it possible for reforms to be attempted one at a time.

Each proposed solution is an idea, not an established cure. Experience from successful and well-monitored programs would be recorded to establish effectiveness. At present no such track-record exists. Consequently, specific attempt must be analyzed, and no effects can be assumed.

Certainly, each offered solution is limited. None will end all need for this group. But many have the advantages of being modest in scope and of promising immediate, if partial relief to certain individuals. To be sure, a rather large increase in resources of all kinds, from an improvement in the economy to massive increases in social services, would accomplish much more. But even without such changes, it may be possible to reduce or eliminate the extensiveness of homelessness for some individuals and families.

References

Albrandt, Karen S. 1986. Responding to the Needs of Homeless People: Assessing the Need for Program Development by Emerging and Existing Service Providers. Chicago: Community Emergency Shelter Organization.

American Psychiatric Association. 1984. The Homeless Mentally Ill. Washington, D.C.: American Psychiatric Association.

Anderson, Nels. 1923. The Hobo: The Sociology of the Homeless. Chicago: The University of Chicago Press.

Appleby, Lawrence and Prakash N. Desai. 1985. "Documenting the Relationship Between Homelessness and Psychiatric Hospitalization." Hospital and Community Psychiatry 36:732-737.

Arce, A.A., M. Tadlock, and M.J. Vergare. 1983. "A Psychiatric Profile of Street People Admitted to Emergency Shelter." Hospital and Community Psychiatry 34:812-17.

Arce, A. Anthony and Michael J. Vergare. 1984. "Identifying and Characterizing the Mentally Ill Among the Homeless," in H. Richard Lamb, ed., The Homeless Mentally Ill. Washington, D.C.: American Psychiatric Association.

Arce, A. Anthony and Michael J. Vergare. 1986. "Mental Illness in the Homeless," in Billy E. Jones, ed., Treating the Homeless: Urban Psychiatry's Challenge. Washington, D.C.: American Psychiatric Press, Inc.

Bachrach, Leona L. 1984. "The Homeless Mentally Ill and Mental Health Services: An Analytical Review of the Literature, " in H. Richard Lamb, ed., The Homeless Mentally Ill. Washington, D.C.: American Psychiatric Association.

Bahr, H. 1973. Skid Row. Oxford: Oxford University Press.

Bahr, H. and Theodore Caplow. 1974. Old Men Drunk and Sober. NY: New York University Press.

Bassuk, Ellen L., ed. 1986. The Mental Health Needs of Homeless Persons. San Francisco, CA: Jossey-Bass.

Bassuk, Ellen L. and Samuel Gerson. 1978. "Deinstitutionalization and Mental Health Services." Scientific American 238:46-53.

Bassuk, Ellen L. and H. Richard Lamb. 1986. "Homelessness and the Implementation of Deinstitutionalization," in Ellen L. Bassuk, ed., The Mental Health Needs of the Homeless. San Francisco, CA: Jossey-Bass.

Bassuk, Ellen L., Lenore Rubin, and Alison Lauriat. 1984. "Is Homelessness a Mental Health Problem?" American Journal of Psychiatry 141:1546-1550.

Baxter, Ellen and Kim Hopper. 1981. Private Lives/Public Spaces: Homeless Adults on the Streets of New York City. NY: Community Service Society.

Bogue, Donald. 1963. Skid Row in American Cities. Chicago: The University of Chicago Press.

Brodkin, Evelyn and Michael Lipsky. 1983. "Quality Control in AFDC as an Administrative Strategy." Social Service Review 57:1-34.

Brown, Carl, Steve MacFarlane, Ron Paredes, and Louisa Stark. 1983. The Homeless of Phoenix: Who Are They? and What Should Be Done? Phoenix: Phoenix South Community Mental Health Center.

Brown, H. James and Milton Yinger. 1986. "Home Ownership and Housing Affordability in the United States: 1963-1985." Cambridge: Joint Center for Housing Studies of the Massachusetts Institute of Technology and Harvard University.

City of Chicago, Department of Planning. 1985. Housing Needs of Chicago's Single, Low-Income Renters.

Committee on Ways and Means, U.S. House of Representatives. 1987. "Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means: 1987 Edition." Washington, D.C.: U.S. Government Printing Office.

Crystal, Stephen, Mervyn Goldstein, and Rosanne Levitt. 1982. Chronic and Situational Dependence: Longterm Residents in a Shelter for Men. NY: Human Resources Administration.

Department of Health and Human Services. 1984. "The Homeless: Background, Analysis and Options." Washington D.C.: Department of Health and Human Services.

Derogatis, Leonard and Philip M. Spencer. 1982. Administration and Procedures: BSI Manual - I. Baltimore, MD.: Clinical Psychometric Research, Division of Medical Psychiatry, Johns Hopkins University, School of Medicine.

Drake, Robert E. and David A. Adler. 1984. "Shelter is Not Enough: Clinical Work with the Homeless Mentally Ill," in H. Richard Lamb, ed., The Homeless Mentally Ill. Washington, D.C.: American Psychiatric Association.

Farr, Rodger K., Paul Koegel, and Audrey Burnam. 1986. "A Study of Homelessness and Mental Illness in the Skid Row Area of Los Angeles." Los Angeles County Department of Mental Health.

Fischer, Pamela J., Sam Shapiro, William Breakey, James Anthony, and Morton Kramer. 1984. "Mental Health and Social Characteristics of the Homeless: A Survey of Mission Users." Paper presented at the 112th Annual Meeting of the American Public Health Association, Anaheim, CA, November 11-15, 1984.

Frazier, Shervert H. 1985. "The Homeless Mentally Ill." Paper presented at the Staff College, Division of Communications and Education, National Institute of Mental Health, Rockville, MD, May 15, 1985.

Freeman, Richard B. and Brian Hall. 1986. "Permanent Homelessness in America?" NY: National Bureau of Economic Research.

Goldfinger, Stephen M. and Linda Chafetz. 1984. "Developing a Better Service Delivery System for the Homeless Mentally Ill," in H. Richard Lamb, ed., *The Homeless Mentally Ill*. Washington, D.C.: American Psychiatric Association.

Goldman, Barbara, Daniel Friedlander, Judith Gueron, and David Long. 1985. *Findings from the San Diego Job Search and Work Experience Demonstration*. NY: Manpower Demonstration Research Corporation.

Gove, Walter C., Michael Hughes, and Omer R. Galla. 1983. *Overcrowding in the Household: An Analysis of Determinants and Effects*. NY: Academic Press.

Gronbjerg, Kirsten A., Madeleine H. Kimmich, and Lester M. Salamon. 1985. *The Chicago Nonprofit Sector in a Time of Government Retrenchment*. Washington, D.C.: Urban Institute Press.

Gronbjerg, Kirsten A., James C. Musselwhite, Jr., and Lester M. Salamon. 1984. *Government Spending and the Nonprofit Sector in Cook County/Chicago*. Washington, D.C.: Urban Institute Press.

Handler, Joel F. and Michael Sosin. 1983. *Last Resorts: Emergency Assistance and Special Needs Programs in Public Welfare*. NY: Academic Press.

Hombs, Mary Ellen and Mitch Snyder. 1982. *Homelessness in America: A Forced March to Nowhere*. Washington, DC.: The Community for Creative Non-Violence.

Hopper, Kim and Jill Hamburg. 1984. *The Making of America's Homeless: From Skid Row to New Poor*. Community Service Society of New York.

Human Services Research Institute. 1984. *Alcohol Abuse/Alcoholism Among Homeless Persons: A Review of the Literature*. Washington, DC.: U.S. Department of Health and Human Services.

Illinois Department of Mental Health and Developmental Disabilities. 1986a. "Response to the Governor's Task Force on the Homeless Recommendations." Unpublished manuscript. September 2, 1986.

Illinois Department of Mental Health and Developmental Disabilities. 1986b. "Report to the General Assembly Pursuant to Public Act 84-366." State of Illinois, WO 86-340. Unpublished manuscript. June, 1986.

Illinois State Budget, Appendix. 1987. Springfield, IL: Illinois Governor.

Johnston, Lloyd D., Patrick M. O'Malley, and Jerald G. Bachman. 1985. *Drug Use Among American High School Students, College Students, and other Young Adults: National Trends Through 1985*. Rockville, MD: U.S. Department of Health and Human Services, National Institute on Drug Abuse.

Katz, Steven. 1986. "Summary," in Billy E. Jones, ed., *Treating the Homeless: Urban Psychiatry's Challenge*. Washington, D.C.: American Psychiatric Press, Inc.

Kaufmann, Charles A. 1984. "Implications of Biological Psychiatry for the Severely Mentally Ill: A Highly Vulnerable Population," in H. Richard Lamb, ed., *The Homeless Mentally Ill*. Washington, D.C.: American Psychiatric Association.

Lamb, H. Richard. 1984. "Deinstitutionalization and the Homeless Mentally Ill," in H. Richard Lamb, ed., *The Homeless Mentally Ill*. Washington, D.C.: American Psychiatric Association.

Lane, Joyce B. and Frederick C. Depp. 1986. *Sheltered Homeless in the Nation's Capitol: A Comparative Study of Characteristics, Needs and Services for Washington, D.C. Homeless Single Adults and Families*. Washington, DC.: Commission on Homeless, Department of Human Services.

League of Women Voters of Illinois. 1986. *Public Policy on Mental Illness in Illinois: A Report by the Mental Health Task Force*. League of Women Voters of Illinois Education Fund.

Levine, Irene S. 1984. "Homelessness: Its Implications for Mental Health Policy and Practice." *Psychosocial Rehabilitation Journal* 8:6-16.

Levine, Irene S. and James Stockdill. 1986. "Mentally Ill and Homeless: A National Problem," in Billy E. Jones, ed., *Treating the Homeless: Urban Psychiatry's Challenge*. Washington D.C.: American Psychiatric Press, Inc.

Lewis, Dan A., Tom Pavkov, Helen Rosenberg, Susan Reed, Arthur Lurigio, Zev Kalifon, Bruce Johnson, and Stephanie Riger. 1987. *State Hospital Utilization in Chicago: People, Problems and Policy*. Evanston, IL: Center for Urban Affairs and Policy Research, Northwestern University.

Lipton, Frank, Albert Sabatini and Peter Micheels. 1986. "Characteristics and Service Needs of the Homeless Mentally Ill," in BIlly E. Jones, ed., Treating the Homeless: Urban Psychiatry's Challenge. Washington, D.C.: American Psychiatric Press, Inc.

Lorian, Raymond P. and Robert Felner. 1986. "Research on Mental Health Interventions with the Disadvantaged," in S.E. Garfield and A.E. Bergin, eds., Handbook of Psychotherapy and Behavior Change. 3rd ed. NY: Wiley.

McDonald, Thomas P., and Irving Piliavin. 1984. "Failure to Participate in AFDC: Some Correlates and Possible Influences." Social Work Research and Abstracts 20:17-22.

McGerigle, Paul and Alison S. Lauriat. 1983. More Than Shelter: A Community Response to Homelessness. Boston: United Community Planning Corporation and Massachusetts Association for Mental Health.

Milburn, N., R. Watts, and S. Anderson. 1984. An Analysis of Current Research Methods for Studying the Homeless. Washington, D.C: Institute for Urban Affairs, Howard University.

Morse, Gary, Nancy M. Shields, and Christina R. Hanneke. 1985. Homeless People in St. Louis: A Mental Health Program Evaluation. Jefferson City, MO: Department of Mental Health.

National Institute on Drug Abuse. 1986. "National Household Survey on Drug Abuse, 1985." NIDA Capsules. Rockville, MD: Department of Health and Human Services.

Piliavin, Irving, Stanley Masters, and Thomas Corbett. 1979. Administration and Organizational Influences and AFDC Case Decision Errors: An Empirical Analysis. Discussion Paper 542-79. Institute for Research on Poverty, University of Wisconsin-Madison.

Quint, Janet, and Cynthia Guy. 1986. Interim Findings from the Illinois WIN Demonstration Program in Cook County. NY: Manpower Demonstration Research Corporation.

Ragan, James F. 1974. Mental Health and Developmental Disabilities in Illinois: An Examination. Springfield, IL.: Illinois Department of Mental Health and Developmental Disabilities.

Report on Projected Expenditures for the Title XX Social Services Block Grant for Fiscal Year 1986. 1985. Springfield, IL: Illinois Department of Public Aid.

Ribton-Turner, C.T. 1887, 1972. History of Vagrants and Vagrancy and Beggars and Begging. Montelaiz, NJ: Patterson Smith (1972 Reprint).

Richman, Harold. 1981. Lecture presented in The History, Philosophy, and Structure of Social Welfare. SSA 300, School of Social Service Administration, University of Chicago, Chicago, IL., February 2, 1981.

Rossi, Peter H., Gene A. Fisher, and Georgianna Willis. 1986. The Condition of the Homeless of Chicago. Chicago, IL: National Opinion Research Center.

Roth, Dee, Jerry Bean, Nancy Lust, and Traian Saveanu. 1985. Homelessness in Ohio: A Study of People in Need, Statewide Report. Ohio Department of Mental Health, Office of Program Education and Research.

Rousseau, Ann Marie. 1981. Shopping Bag Ladies. NY: The Pilgrim Press.

Sakano, D. 1981. "Homeless New Yorkers: The Forgotten Among Us" (testimony given at the New York State Assembly hearings, November 19, 1981), cited in Madeleine R. Stoner, 1983. "The Plight of Homeless Women," Social Service Review 57:565-581.

Simon, William H. 1983. "Legality, Bureaucracy, and Class in the Welfare System." Yale Law Journal 92:1198-1269.

Social Security Bulletin. 1986, 1976. Annual Statistical Supplement.

Sosin, Michael. 1986. Private Benefits: Material Assistance in the Private Sector. Orlando, FL: Academic Press.

Sosin, Michael. 1986. "Legal Rights and Welfare Change, 1960-1980," in Sheldon H. Danziger and Daniel H. Weinberg, eds., Fighting Poverty: What Works and What Doesn't. Cambridge: Harvard University Press.

Sosin, Michael. 1987. "General and Emergency Assistance," in Encyclopedia of Social Work, 18th Edition. NY: National Association of Social Workers.

Stagner, Matthew, and Harold Richman. 1985. General Assistance Profiles: Findings from a Longitudinal Study of Newly Approved Recipients. Chicago: Social Policy Research Center, the University of Chicago.

Stern, Mark J. 1984. "The Emergence of Homelessness as a Public Problem." Social Service Review 58:291-301.

Stevens, Anne O'Brien, Les Brown, Paul Colson, and Karen Singer. 1983. "When You Don't Have Anything": A Survey of Homeless People in Chicago. Chicago: Chicago Coalition for the Homeless.

Sutherland, Edwin M., and Harvey J. Locke. 1936. Twenty Thousand Homeless Men. Chicago: J.P. Lippincott.

United States of America. 1987. Economic Report of the President. Washington, DC: United States Government Printing Office.

University of Illinois at Chicago, School of Public Health, Department of Health Resources Management. 1987. "Report Series: Mental Health Crisis Screening in Chicago: Report #1: State-Operated Facility Utilization and Relative Need for Community Service Funding in Illinois." Unpublished manuscript. September 4, 1987.

United States Bureau of the Census. 1983. Annual Housing Survey: 1979. Washington, DC: U.S. Department of Commerce.

United States Bureau of the Census. 1984. "Geographical Mobility: March 1982 to March 1983." Current Population Reports, Series P-20, #393. Washington, D.C.: U.S. Government Printing Office.

United States Bureau of the Census. 1987. Annual Housing Survey: 1983. Washington, DC: U.S. Department of Commerce.

U.S. Department of Housing and Urban Development. 1984. A Report to the Secretary on the Homeless and Emergency Shelters. Washington, DC: Office of Policy Development and Research.

Wallen, Margery. 1984. Deinstitutionalization of the Mentally Ill and Developmentally Disabled in Illinois: Adequacy of Care Issues in Community and Institutional Settings. Illinois Bureau of the Budget, Health and Human Services Division, September 27, 1984.

Williams, Donald H., Elizabeth C. Bellis, and Sheila W. Wellington. 1980. "Deinstitutionalization and Social Policy: Historical Perspectives and Present Dilemmas." American Journal of Orthopsychiatry 50:54-65.

Appendix A

Table A1

Selected Demographic Characteristics of Homeless Respondents: Hospitalized Versus Never Hospitalized Persons

Attribute	Total Homeless Sample	Never Hosp. Homeless	Hosp. Homeless
Mean age:	37.93 (341)	38.01 (272)	37.65 (69)
Race:			
Black	67.6% (339)	68.9% (271)	62.7% (68)
Other	32.4% (339)	31.1% (271)	37.3% (68)
Sex:			
Male	73.1% (343)	73.8% (275)	70.4% (68)
Female	26.9% (343)	26.2% (275)	29.6% (68)
Marital status:			
Ever married	44.0% (342)	42.4% (274)	50.6% (68)
Never married	56.0% (342)	57.6% (274)	49.4% (68)
Currently married	4.9% (342)	5.4% (274)	2.8% (68)
Mean years of education:	10.98 (342)	10.97 (273)	11.01 (69)
Highest weekly individual income (in 1977 dollars)	$236.37 (299)	$235.89 (241)	$238.33 (58)

(Continued on next page)

Table A1--Continued

Attribute	Total Homeless Sample	Never Hosp. Homeless	Hosp. Homeless
Percent time worked as adult	63.2% (344)	53.6% (275)	51.8% (69)
Percent in childhood out-of-home care	14.4% (343)	13.4% (274)	18.4% (69)
Percent who consumed any alcohol in the past 30 days	60.4% (344)	62.5% (275)	52.4% (69)
Percent of sample who go on binge drinking	21.9% (342)	21.4% (274)	23.7% (68)

Numbers and percents are rounded.

Table A2

Ever Versus Never Hospitalized Homeless Respondents: Selected Variables Related to Previous and Current Living Situations

Attribute	Total Homeless Sample	Never Hosp. Homeless	Hosp. Homeless
Percent in female headed families in most recent living arrangement	15.8% (324)	16.0% (257)	14.8% (67)
Percent currently living alone	65.6% (324)	62.1% (257)	79.2%** (67)
Percent living alone in their last living situation	49.0% (322)	46.0% (257)	60.9%* (65)

Numbers and percents are rounded.

For ever hospitalized and never hospitalized comparison:

* $p < .05$
** $p < .01$

Table A3

Medication Compliance and Outpatient Treatment Patterns

A. INITIAL RECEIPT OF OUTPATIENT TREATMENT AND MEDICATION PRESCRIPTION

	Total (63)	Received Tx (48)	Did not Receive Tx (15)
Medication prescribed	42.3%	45.0%	55.0%
No Med. Prescribed	57.6%	34.0%	66.0%

B. STILL RECEIVING TREATMENT AND COMPLIANCE PATTERNS

	Total (22)	Still Receive Treatment (18)	Not Receiving Treatment (4)
Always Take as Prescribed	54.3%	86.5%	13.5%
Sometimes Take as Prescribed	40.7%	78.8%	21.2%
Never Take as Prescribed	5.0%	100.0%	0%

Numbers and percents are rounded.

Table A4

Outpatient Treatment Patterns in Relation to Mean Scores on Selected Global Measures of the BSI

REFERRED TO OUTPATIENT TREATMENT

	Yes # (62)	No (16)
GSI	.80	1.05
PST	29.01	27.56
PSDI	2.05	1.95

IF TOLD, RECEIVED OUTPATIENT TREATMENT

	Yes # (48)	No (15)
GSI	1.15	1.49
PST	27.23	34.70
PSDI	1.99	2.22

IF RECEIVED, STILL RECEIVING

	Yes # (24)	No (25)
GSI	1.46	.80
PST	29.91	23.26
PSDI	2.25	1.70

Numbers and percents are rounded.

#The number of persons included in the analysis fluctuated according to the scale being used. The number reported was the number who were included in the analysis for the GSI. In all cases where numbers were inconsistent, there was one less person included in the analysis for the PSDI and one more person included for the PST analysis.

Table A5

Outpatient Treatment Patterns in Relation to Whether Respondents were Above or Below the Cutoff Point Indicating a Need for Treatment from the BSI

A. REFERRED FOR TREATMENT	Total (77)	Yes (62)	No (15)
Below the cutoff indicating the need for treatment	30.3%	79.3%	20.7%
Above the cutoff, treatment indicated	69.7%	81.5%	18.5%
B. RECEIVED TREATMENT	**Total (62)**	**Yes (47)**	**No (15)**
Below the cutoff indicating the need for treatment	29.7%	91.4%	8.6% #
Above the cutoff, treatment indicated	70.3%	69.3%	30.7%
C. STILL RECEIVING TX	**Total (48)**	**Yes (24)**	**No (24)**
Below the cutoff indicating the need for treatment	37.2%	34.4%	65.6% #
Above the cutoff, treatment indicated	62.8%	59.3%	40.7%

Numbers and percents are rounded.

#There is some indication of significant differences between those who did and did not receive treatment and those who are or are not still receiving it. In both cases, $p < .10$.

Table A6

Outpatient Treatment Patterns in Relation to Views of Oneself as Mentally Ill

TOLD ABOUT OUTPATIENT TREATMENT

	TOTAL (79)	View Self as Mentally Ill (30)	Do not View Self as Mentally Ill (49)
Yes	80.3%	41.5%	58.5%
No	19.7%	24.1%	75.9%

IF TOLD, RECEIVED OUTPATIENT TREATMENT

	TOTAL (63)	View Self as Mentally Ill (26)	Do not View Self as Mentally Ill (37)
Yes	76.3%	44.4%	55.6%
No	23.7%	32.1%	67.9%

IF RECEIVED, STILL RECEIVING TREATMENT

	TOTAL (49)	View Self as Mentally Ill (21)	Do not View Self as Mentally Ill (28)
Yes	51.1%	42.5%	57.5%
No	48.9%	44.5%	55.5%

Numbers and percents are rounded.

Table A7

Mean BSI Scores for Hospitalized Versus Never Hospitalized Respondents: Ever Versus Never Homeless

SCALE		Hospitalized (n = 84)	Never Hosp. (n = 440)
SOMATIZATION	**NH**	1.00 (16)	.38 (164)
	Hmls	.88 (68)	.44 (276)
OBSESSIVE COMPULSIVE	**NH**	.94	.59
	Hmls	1.39	.69
INTERPERSONAL SENSITIVITY	**NH**	.96	.59
	Hmls	1.34	.79
DEPRESSION	**NH**	.99	.45
	Hmls	.99	.72
ANXIETY	**NH**	1.04	.48
	Hmls	1.33	.68
HOSTILITY	**NH**	1.07	.55
	Hmls	1.10	.68
PHOBIA	**NH**	.84	.42
	Hmls	1.10	.49
PARANOIA	**NH**	1.24	1.01
	Hmls	1.65	1.10
PSYCHOTICISM	**NH**	.97	.43
	Hmls	1.02	.63
ADDITIONAL ITEMS	**NH**	1.13	.58
	Hmls	1.32	.76
GSI	**NH**	1.01	.54**
	Hmls	1.23	.67
PST	**NH**	26.95	16.41
	Hmls	28.52 (69)	20.02
PSDI	**NH**	1.76 (15)	1.65 (154)
	Hmls	2.10 (67)	1.71 (266)

Numbers and percents are rounded.

**Significant differences existed among the never hosp. homeless and never homeless at < .01 level. The hosp. groups did not differ significantly on this scale.

Table A8

Proportion Above and Below the 98th Percentile on the GSI for Never Hospitalized Respondents: Never Versus Ever Homeless

	Total (439)	Never Homeless (164)	Ever Homeless (275)
Score is below the 98th percentile	78.7%	86.1%	74.3%
Score is within the 98th percentile	21.3%	13.9%	25.7%**

Numbers and percents are rounded.

** $p < .01$

Table A9

Proportion Above and Below the 98th Percentile on the GSI for Never Hospitalized Respondents: Never Versus Currently Homeless

	Total (304)	Never Homeless (164)	Currently Homeless (140)
Score is below the 98th percentile	83.9%	86.1%	81.3%
Score is within the 98th percentile	16.1%	13.9%	18.7%

Numbers and percents are rounded.

Appendix B

Table B1

Use of Services and Opinions of Agency Use

	Total Sample			
	Presently Using Services	Not Presently Using Services	Past Service Use	No Past Use
Opinions:				
"Most services don't really help people."	28.8% (137)	37.3% (350)	34.6% (458)	37.8% (31)
"Most services aren't worth the time and effort."	27.9% (136)	28.0% (355)	28.0% (462)	26.8% (31)
"Talking to workers is too personal."	26.4% (141)	27.3% (363)	27.5% (474)	18.8% (32)
"Don't need help."	22.0% (140)	21.3% (363)	21.3% (471)	22.6% (33)

	Currently Homeless			
	Presently Using Services	Not Presently Using Services	Past Service Use	No Past Use
Opinions:				
"Most services don't really help people."	31.4% (54)	40.8% (108)	37.6% (157)	33.3% (6)
"Most services aren't worth the time and effort."	32.0% (53)	26.6% (108)	28.9% (155)	12.4% (6)
"Talking to workers is too personal."	35.3% (55)	25.6% (116)	29.1% (166)	12.4% (6)
"Don't need help."	23.9% (54)	15.7% (113)	18.3% (161)	16.8% (6)

(Continued on next page)

Table B1--Continued

	Not Currently Homeless			
	Presently Using Services	Not Presently Using Services	Past Service Use	No Past Use
Opinions:				
"Most services don't really help people."	27.2% (83)	35.7% (241)	33.0% (300)	38.8% (25)
"Most services aren't worth the time and effort."	25.3% (83)	28.7% (248)	27.5% (307)	30.5% (25)
"Talking to workers is too personal."	20.7% (86)	28.1% (247)	26.6% (309)	20.4% (25)
"Don't need help."	20.7% (86)	23.8% (250)	22.8% (310)	24.0% (27)

Differences were not statistically significant at or below .05 level.

Note: Numbers and percents are rounded.